

Item 4 per phone 2/24/82 dad

STATE OF MARYLAND

DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 2 0 3 4 9 1

1- FOR
STATE
REGISTRAR

REG. NO.

1. DECEASED NAME
(TYPE OR PRINT)

FIRST

MIDDLE

LAST

PATRICIA A ABEL

2a. DATE OF DEATH

2-12-82

2b. HOUR
120 P.M.

3. SEX

F

4. RACE

Caucasian

5. DATE OF BIRTH

4-4-54

6. AGE (IN YEARS LAST BIRTHDAY)

27

IF UNDER 1 YEAR

MONTHS

IF UNDER 72 HRS.

DAYS

HOURS

MIN.

7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)

WILMINGTON, DEL.

7b. CITIZEN OF WHAT COUNTRY?

U.S.A.

8. MARRIED ☐ NEVER MARRIED ☐WIDOWED ☐ DIVORCED ☒

9. BALTIMORE CITY OR COUNTY OF DEATH

Baltimore City MD.

10. CITY OR TOWN OF DEATH

Baltimore

11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION

UNIV OF MD Hospital

12a. USUAL OCCUPATION

None

12b. KIND OF BUSINESS OR INDUSTRY

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

13a. STATE

Delaware

13b. COUNTY

New Castle

13c. CITY OR TOWN

New Castle

13d. INSIDE CITY LIMITS?

YES ☐ NO ☒

13e. STREET ADDRESS

Collins 214 Keiser Place, Park

14. FATHER'S NAME

FIRST

MIDDLE

LAST

Francis J. Carroll, Sr.

15. MOTHER'S MAIDEN NAME

FIRST

MIDDLE

LAST

Eva A. Brittingham Carroll

16a. WAS DECEASED EVER IN U.S. ARMED FORCES?

(YES, NO OR UNKNOWN)

No

16b. SOCIAL SECURITY NO.

(IF YES, GIVE WAR OR DATES)

221-42-3639

17. INFORMANT

ADDRESS

Francis J. Carroll, Sr. 214 Keiser Place

(Father)

New Castle, De.

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART 1. DEATH WAS CAUSED BY

IMMEDIATE CAUSE (a)

2050

ACUTE PROMYELOCYTIC LEUKEMIA

DUE TO, OR AS A CONSEQUENCE OF

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

(b)

DUE TO, OR AS A CONSEQUENCE OF

(c)

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH, NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)

SEPSIS; RENAL FAILURE

19a. DATE OF OPERATION

19b. CONDITION FOR WHICH OPERATION WAS PERFORMED

20a. AUTOPSY?

YES ☒ NO ☐

20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?

YES ☐ NO ☒21a. ACCIDENT WAS UNEXPECTED OR CONTRIBUTING ☒ DEATH

(IF EITHER, NOTIFY MEDICAL EXAMINER)

21b. TIME OF INJURY

HOUR A.M. MONTH DAY YEAR

P.M. 19

21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)

21d. INJURY OCCURRED

WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21e. PLACE OF INJURY

(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)

21f. LOCATION

STREET

CITY OR TOWN

COUNTY

STATE

22a. I certify that (I) (this hospital) attended the deceased from 2-5-82 to 2-12-82, that (I) (we) lost saw the deceased alive on 2-12-82, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (do) not view the body after death.

22b. SIGNATURE

Vundhar V. Reddy

DEGREE

MD

22c. DATE SIGNED

2/12/82

22d. PHYSICIAN'S NAME (TYPE OR PRINT)

Vundhar V. Reddy

22e. ADDRESS

UNIV OF MD Hospital

BALTIMORE, MD, 21201

23a. BURIAL, CREMATION, REMOVAL

Entombment

23b. DATE

Feb. 17, 1982

23c. NAME OF CEMETERY OR CREMATORY

Gracelawn Mem. Pk.

23d. LOCATION

CITY OR TOWN

COUNTY

N.C., Del.

STATE

24. FUNERAL DIRECTOR

NAME

R. J. Ford

ADDRESS

Chesapeake City, Md.

25a. DATE RECD. BY REGISTRAR

FEB 18 1982

25b. REGISTRAR'S SIGNATURE

[Signature]

44

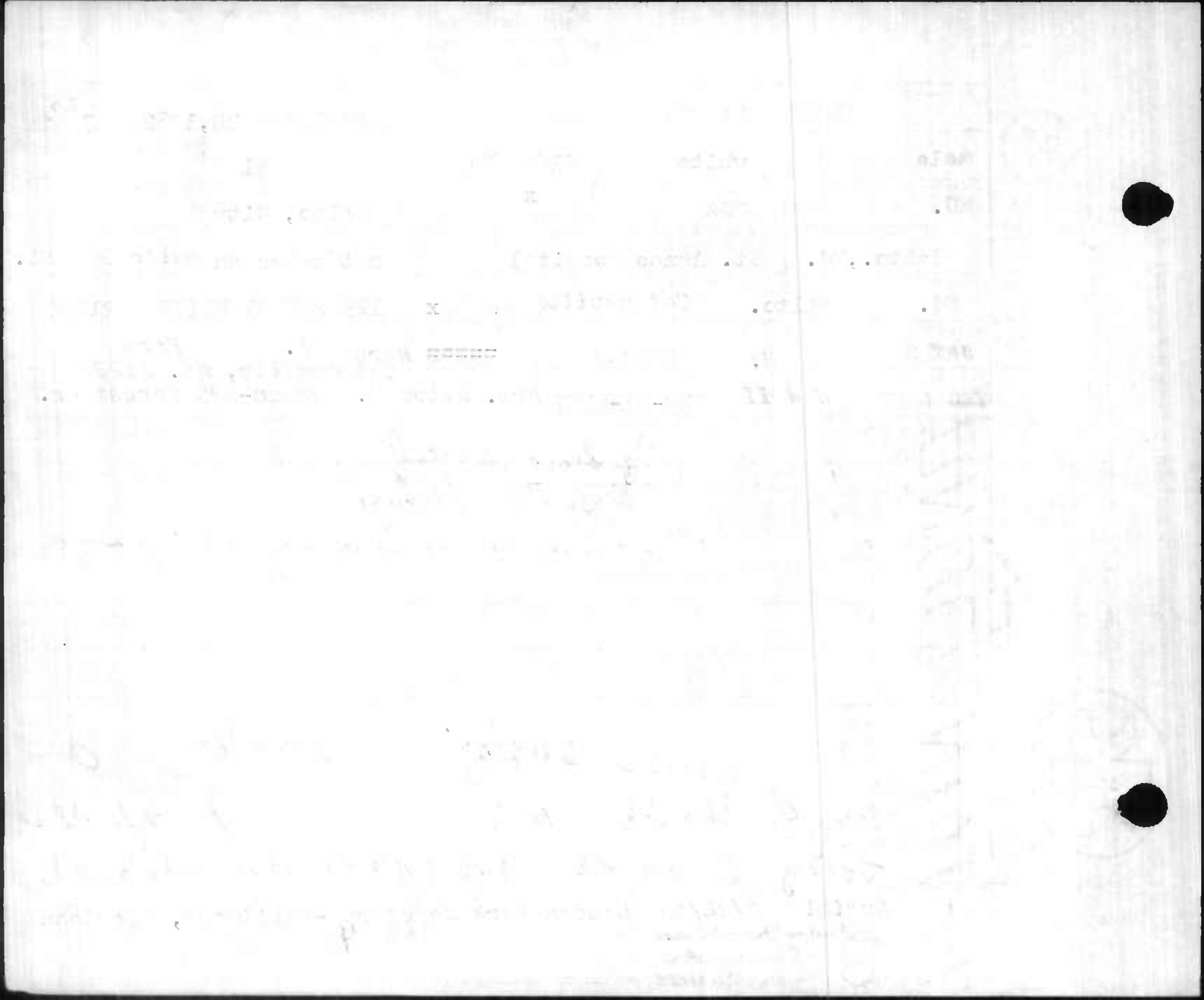


TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be called to examine the body.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										8 2 0 3 4 9 2		
1. FOR STATE REGISTRAR					REG. NO.							
1. DECEASED NAME (TYPE OR PRINT) WILBUR FRANCIS ACKMAN					2a. DATE OF DEATH FEBRUARY 20, 1982					2b. HOUR 9 ²⁵ P.M.		
3. SEX male		4. RACE white		5. DATE OF BIRTH 01/28/21			6. AGE (IN YEARS LAST BIRTHDAY) 61 YRS.			IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.		
7a. BIRTHPLACE (STATE OR FOREIGN) MD.		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH Balto., City MD.					
10. CITY OR TOWN OF DEATH Balto., Md.		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) St. Agnes Hospital					12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) ret/salesman			12b. KIND OF BUSINESS OR INDUSTRY Balto G & El.		
13a. STATE Md.					13b. COUNTY Balto.		13c. CITY OR TOWN Catonsville		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS 125 FOREST DRIVE 21228	
14. FATHER'S NAME JAMES H. ACKMAN					15. MOTHER'S MAIDEN NAME AGNES Mary A. Ford							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) YES ARMY					16b. SOCIAL SECURITY NO. W W 71 220-01-6507		17. INFORMANT Mrs. Nelva C. Ackman-125 Forest Dr.					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Carbide arrest</u> <u>1629</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>Respiratory failure</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) <u>Terminal metastatic Squamous Cell Carcinoma of Lung</u> PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OF CONDITION GIVEN IN PART 1: a										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)						
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE						
22a. I certify that (1) (this hospital) attended the deceased from <u>2/20/82</u> 19 <u>82</u> to <u>2/20/82</u> 19 <u>82</u> , that (1) we last saw the deceased alive on <u>2/20/82</u> 19 <u>82</u> and that in my (our) opinion death occurred on the date and hour and from the causes stated above (1) we (did) (did not) view the body after death.												
22b. SIGNATURE Jerry D. Skarbek					DEGREE M.D. ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>					22c. DATE SIGNED 2/20/82		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Jerry D. Skarbek					22e. ADDRESS 900 Catons Ave Balto, Md.							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE 2/24/82		23c. NAME OF CEMETERY OR CREMATORY Loudon Park Cemetery			23d. LOCATION CITY OR TOWN COUNTY STATE Baltimore, Maryland				
24. FUNERAL DIRECTOR NAME Sterling Funeral Estate 736 Edmondson Ave. Catonsville, Md. 21228					25. DATE RECEIVED BY TRANSFER AGENT FEB 24 1982							



TO HOSPITAL AND ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the registrars, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

Item 8 g566 4/21/82 gj

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST CARLOS M. ACOSTA Sr.			2a. DATE OF DEATH MONTH DAY YEAR 2 26 82		2b. HOUR 5:30pm						
3 SEX MALE		4 RACE Puerto Rican		5 DATE OF BIRTH MONTH DAY YEAR 3 14 16		6 AGE (IN YEARS LAST BIRTHDAY) 65 YRS.		7 UNDER 1 YEAR MONTHS DAYS 0 0		7 UNDER 24 HRS HOURS MIN. 0 0	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Puerto Rico		7b. CITIZEN OF WHAT COUNTRY? USA		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH Baltimore City MD.					
10 CITY OR TOWN OF DEATH Baltimore		11 NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Provident Hospital				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY			
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)											
13a. STATE MD		13b. COUNTY		13c. CITY OR TOWN Baltimore		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 3414 Hilldale Place			
14 FATHER'S NAME FIRST MIDDLE LAST Raymon Acosta				15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Marie							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 054-10-1945		17 INFORMANT ADDRESS Corrine Acosta 3414 Hilldale Place							
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) cardiovascular arrest 4100 DUE TO, OR AS A CONSEQUENCE OF (b) cardiac shock DUE TO, OR AS A CONSEQUENCE OF (c) extreme myocardial infarction										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) subcoronary accident											
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (this hospital) attended the deceased from 2/26 , 19 82 , to 2/26 , 19 82 , that (I) (we) last saw the deceased alive on 2/26 , 19 82 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE Juan E. Ruffier						DEGREE MD			22c. DATE SIGNED 2/26/82		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) JUAN E. RUFFIER						22e. ADDRESS					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE 3/3/82		23c. NAME OF CEMETERY OR CREMATORY Cedar Hill Cem.			23d. LOCATION CITY OR TOWN COUNTY STATE Anne Arundel Co. MD			
24. FUNERAL DIRECTOR NAME ADDRESS Wm. C. March F/H 1101 E. North Ave.						25a. DATE REC'D. BY REGISTRAR MAR 1 1982			25b. REGISTRAR'S SIGNATURE James J. Nathan		

White

White

White

White

White

White

White

White

White

024-10-1992 Corrine Acosta 3414 Millvale Place
Acosta Marie
024-10-1992 Corrine Acosta 3414 Millvale Place

024-10-1992 Corrine Acosta 3414 Millvale Place

024-10-1992 Corrine Acosta 3414 Millvale Place

024-10-1992 Corrine Acosta 3414 Millvale Place

Items 5,6 g566 4/21/82 gj

FOR
1. STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 2 0 3 4 9 4

REG. NO.

1. DECEASED NAME (TYPE OR PRINT)		FIRST	MIDDLE	LAST	2a. DATE OF DEATH MONTH DAY YEAR	2b. HOUR M
Barbara		E.		Acree	2-18-82	6:40P
3. SEX	4. RACE	5. DATE OF BIRTH MONTH DAY YEAR		6. AGE (IN YEARS LAST BIRTHDAY)	IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.	
Female	Black	Oct 29 1956		26 25 YRS		
7b. BIRTHPLACE (STATE OR FOREIGN COUNTRY)	7c. CITIZEN OF WHAT COUNTRY?	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH		
Maryland	USA			Baltimore City MD		
10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY
Balto.	John Hopkins Hospital			Security Guard		
13a. STATE	13b. COUNTY	13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET ADDRESS	
Md	-	Balto.			130 Arisquith St	
14. FATHER'S NAME FIRST MIDDLE LAST		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST				
Archie H. Smith		Corrine Smith				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES)		17. INFORMANT ADDRESS		
No		214-68-3774		Darnell Acree - 130 Arisquith St		

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY:		APPROPRIATE INTERVAL BETWEEN ONSET AND DEATH
IMMEDIATE CAUSE (a) 4290 Cardiac Arrest		12 hours
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.	(b) Myocarditis - pericarditis	12 days
	(c)	

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)			
Pericardial effusion with tamponade			
19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	19c. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	19d. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	20b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19	20c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21a. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>	21b. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21c. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (his hospital) attended the deceased from Feb 7 19 82, to Feb 18 19 82, that (I) (we) lost saw the deceased alive on Feb 18 19 82, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) did (I) (we) did not view the body after death.		22b. DATE SIGNED Feb 18/82	
22a. SIGNATURE BB Bolger MD		22b. ADDRESS Johns Hopkins Hospital 600 N Wolfe Street Baltimore	
22c. PHYSICIAN'S NAME (TYPE OR PRINT) Bolger		22d. ADDRESS Johns Hopkins Hospital 600 N Wolfe Street Baltimore	
23a. BURIAL, CREMATION, REMOVAL	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION CITY OR TOWN COUNTY STATE
Burial	2/23/82	Md Veteran	Crownsville AA. Md
24. FUNERAL DIRECTOR NAME ADDRESS		25a. DATE REC'D. BY REGISTRAR	25b. REGISTRAR'S SIGNATURE
Burnell B. Qden Balto. Md		FEB 22 1982	James J. Hester

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours of death, and that it be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, it should be detached for use on the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

0501 BP
DHMH - 16 50M 1/81
(VRA 15, 4)

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TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, REASON FOR DELAY SHOULD BE STATED IN ITEM 18. IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. GIVE PAGES 4 AND 5 TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

DHMH - 17
(VR A15 ME (5))
15M 2/80

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

1. FOR STATE REGISTRAR		2. DATE KNOWN OF DEATH		3. MONTH		4. DAY		5. YEAR		6. HOUR	
1. DECEASED NAME (TYPE OR PRINT)		2. DATE KNOWN OF DEATH		3. MONTH		4. DAY		5. YEAR		6. HOUR	
Doris S. Adams		XX 2 14 1982		2		14		1982		M	
7. SEX	8. RACE	9. DATE OF BIRTH	10. AGE (IN YEARS)	11. IF UNDER 1 YR.	12. IF UNDER 24 HRS.	13. DATE PRONOUNCED DEAD	14. MONTH	15. DAY	16. YEAR	17. HOUR	18. MIN.
Female	White	9 - 19 - 1903	78 YRS.	MONTHS	DAYS	2	14	1982	9:45	A.	M
19. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		20. CITIZEN OF WHAT COUNTRY?		21. MARRIED		22. NEVER MARRIED		23. DIVORCED		24. BALTIMORE CITY OR COUNTY OF DEATH	
Maryland		U.S.A.		WIDOWED		NEVER MARRIED		DIVORCED		Baltimore City, MD	
25. CITY OR TOWN OF DEATH		26. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION		27. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		28. KIND OF BUSINESS OR INDUSTRY					
Baltimore		Johns Hopkins Hospital		Homemaker							
29. USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)		30. STATE		31. COUNTY		32. CITY OR TOWN		33. STREET ADDRESS			
Maryland						Baltimore		3404 Cardenas Ave. 21207			
34. FATHER'S NAME		35. MOTHER'S MAIDEN NAME		36. ADDRESS							
Jacob Schlutter		Mathilda Paff		7 Airway Circle							
37. WAS DECEASED EVER IN U.S. ARMED FORCES?		38. SOCIAL SECURITY NO.		39. INFORMANT		40. ADDRESS					
No		213-34-3728		Mr. William R. Adams Jr.		Towson, Md. Apt					
41. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)										42. APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART I DEATH WAS CAUSED BY:											
IMMEDIATE CAUSE (a) Multiple Visceral and Skeletal Injuries											
DUE TO, OR AS A CONSEQUENCE OF											
(b)											
DUE TO, OR AS A CONSEQUENCE OF											
(c)											
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).											
43. DATE OF OPERATION		44. CONDITION FOR WHICH OPERATION WAS PERFORMED?						45. AUTOPSY?			
								YES		NO	
46. EXTERNAL CAUSE WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH		47. TIME OF INJURY		48. HOW INJURY OCCURRED							
XX		11:20 AM 2 12 1982		pedestrian struck by auto							
49. INJURY OCCURRED WHILE AT WORK		50. PLACE OF INJURY		51. LOCATION							
NOT WHILE AT WORK		b street		Belair Rd. north of Kentucky Ave., Bal to., Md.							
52. I certify that I took charge of the remains described above, held on death resulted from: Natural causes, Accident, Suicide, Homicide, Undetermined manner.											
Autopsy, Inspection, Inquiry, and in my opinion.											
Actual Signature: Virginia L. Dolan, M.D. Assistant Medical Examiner											
Examiner's Name: Virginia L. Dolan, M.D. Address: 111 Penn Street											
53. BURIAL, CREMATION, REMOVAL		54. DATE		55. NAME OF CEMETERY OR CREMATORY		56. LOCATION		57. COUNTY		58. STATE	
Burial		2-17-82		Baldwin Mem. Church Cem.		Millersville, Maryland					
59. FUNERAL DIRECTOR		60. ADDRESS		61. DATE REC'D. BY REGISTRAR		62. REGISTRAR'S SIGNATURE					
Ruck Towson Funeral Home, Inc.		1050 York Rd. Towson, Md. 21204		FEB 16 1982		Thomas J. [Signature]					

BP

0831

1 - 2 -

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1.1.23

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified prior to burial.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

72 03496

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST LOUISE M. AKEHURST		2a. DATE OF DEATH MONTH DAY YEAR February 5, 1982		2b. HOUR 6:00 PM	
3. SEX Female	4. RACE White	5. DATE OF BIRTH MONTH DAY YEAR Oct. 16, 1895		6. AGE (IN YEARS LAST BIRTHDAY) 86 YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland	7b. CITIZEN OF WHAT COUNTRY? USA	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City MD.	
10. CITY OR TOWN OF DEATH Baltimore	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 1182 E. Northern Parkway		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Homemaker		12b. KIND OF BUSINESS OR INDUSTRY Own Home
13a. STATE Maryland		13b. COUNTY Baltimore	13c. CITY OR TOWN Baltimore	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET ADDRESS 1182 E. Northern Parkway
14. FATHER'S NAME FIRST MIDDLE LAST T. Clark		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Emily L. Faulkner		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No	
16b. SOCIAL SECURITY NO. 216 46 3009		17. INFORMANT Alice Akehurst		ADDRESS Same	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Admitted Agreed</u> 4292 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Admitted Arteriosclerotic</u> (c) <u>Anticoagulant & ...</u>					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 1 year. years.
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from 19 76 to 2/05 19 82, that (I) (we) last saw the deceased alive on 1/29 19 82, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did not) view the body after death.					
22b. SIGNATURE Dr. Gracilio Patricio, M.D.				22c. DATE SIGNED 2/5/82	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Dr. Gracilio Patricio, M.D.				22e. ADDRESS 2926 E. Cold Spring Lane, Balto., Md.	
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 2/8/82		23c. NAME OF CEMETERY OR CREMATORY Moreland	
23d. LOCATION CITY OR TOWN COUNTY STATE Balto. Co., Md.		23e. DATE REC'D. BY REGISTRAR FEB 8 1982			
24. FUNERAL DIRECTOR NAME Henry W. Jenkins & Sons Co. ADDRESS 4905 York Road Balto., Md. 21212				25. REGISTRAR'S SIGNATURE James J. ...	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral home, it should be detached for use on the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										8 2 0 3 4 9 7			
1. FOR STATE REGISTRAR		REG. NO.											
1. DECEASED NAME (TYPE OR PRINT) Edward J. Albers						2a. DATE OF DEATH February 17, 1982				2b. HOUR 9 P M			
3. SEX Male		4. RACE White		5. DATE OF BIRTH July 10, 1903		6. AGE (IN YEARS LAST BIRTHDAY) 78		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City MD.							
10. CITY OR TOWN OF DEATH Baltimore		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 2826 Huntingdon Avenue				12a. USUAL OCCUPATION (TYPE WORK OR MOST OF WORKING LIFE) Machinest		12b. KIND OF BUSINESS OR INDUSTRY B&O					
13a. STATE Maryland						13b. COUNTY		13c. CITY OR TOWN Baltimore		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
14. FATHER'S NAME FIRST MIDDLE LAST Henry Albers						15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Mary Gallagher							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No				16b. SOCIAL SECURITY NO. 705 03 9463		17. INFORMANT ADDRESS Joseph Albers 5728 Newholme Ave. 21206							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY 4100 IMMEDIATE CAUSE (a) <u>Acute myocardial infarct</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) <u>Hypertensive vascular disease</u> DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>sudden</u> <u>years</u>													
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <u>Diabetes mellitus</u>													
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE							
22a. I certify that (I) (this hospital) attended the deceased from <u>5/23</u> , 19 <u>77</u> , to <u>2/17</u> , 19 <u>82</u> , that (I) (we) lost saw the deceased alive on <u>2/8</u> , 19 <u>82</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.													
22b. SIGNATURE <u>Reuben Hoffman</u>						DEGREE <u>M.D.</u>		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED <u>2/19/82</u>			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Dr. Reuben Hoffman						22e. ADDRESS 846 W. 36th Street Baltimore, Md.							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Cremation				23b. DATE 20 Feb. 1982		23c. NAME OF CEMETERY OR CREMATORY Westview Mem. Park		23d. LOCATION CITY OR TOWN COUNTY STATE Baltimore, Maryland					
24. FUNERAL DIRECTOR NAME Burgess Funeral Home, 3631 Falls Rd. 21211						25a. DATE REC'D. BY REGISTRAR FEB 19 1982		25b. REGISTRAR'S SIGNATURE <u>James J. [Signature]</u>					



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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be filed within 72 hours after death. The medical examiner must be notified in writing.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified in writing.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 2 0 3 4 9 8

1- FOR STATE REGISTRAR		REG. NO.	
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST ROBERT FRANCIS ALDERTON		2a. DATE OF DEATH MONTH DAY YEAR 2 8 82	
3 SEX MALE		2b. HOUR 7:04a M	
4 RACE WHITE		5. DATE OF BIRTH MONTH DAY YEAR 8 19 24	
6. AGE (IN YEARS LAST BIRTHDAY) YRS. MONTHS DAYS 57		7. IF UNDER 1 YEAR IF UNDER 24 HRS MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MARYLAND		7b. CITIZEN OF WHAT COUNTRY? U.S.A.	
8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE CITY, MD.	
10. CITY OR TOWN OF DEATH BALTIMORE		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) VETERANS ADMINISTRATION MEDICAL CENTER Locksmith	
12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) City Jail		12b. KIND OF BUSINESS OR INDUSTRY Balto.	
13a. STATE MARYLAND		13b. COUNTY BALTIMORE	
13c. CITY OR TOWN BALTIMORE		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
13e. STREET ADDRESS 118 E. 25th Street 21218		14. FATHER'S NAME FIRST MIDDLE LAST LOWELL E. ALDERTON	
15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST MARY E. Stephenson		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) YES WWII	
16b. SOCIAL SECURITY NO. 215128445		17. INFORMANT ADDRESS VAMC MEDICAL RECORD 3900 LOCH RAVEN BLVD	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiopulmonary Arrest 2500 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Coronary Artery Disease (c) Diabetes Mellitus APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH minutes years years			
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:			
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	
20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR 19	
21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1b, PART 1 OR PART 2)		21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	
21e. PLACE OF INJURY (AT HOME STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (X) (this hospital) attended the deceased from JANUARY 28 82 to FEBRUARY 8 82 , and that in my (a) (our) opinion death occurred on the date and hour and from the causes stated above. (we) (did) <input checked="" type="checkbox"/> view the body after death.		22b. SIGNATURE OF PHYSICIAN (TYPE OR PRINT) DEGREE D. J. Somers MD PhD	
22c. PHYSICIAN'S NAME (TYPE OR PRINT) ADDRESS 3900 LOCH RAVEN BLVD. BALTO. MD 21218		22d. DATE SIGNED 2/8/82	
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 2/10/82	
23c. NAME OF CEMETERY OR CREMATORY Crownsville Vet. Cem.		23d. LOCATION CITY OR TOWN COUNTY STATE Crownsville A.A. Co. Md.	
24. FUNERAL DIRECTOR NAME ADDRESS Hubbard Funeral Home, Inc. 4107 Wilkens Ave. 21229		25a. DATE REC'D. BY REGISTRAR FEB 11 1982	
25b. REGISTRAR'S SIGNATURE Francis J. VanNathan			

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

Item 8 g566 4/21/82 gj

1- FOR
STATE
REGISTRAR

Rose

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 2 0 3 4 9 9

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) Attbrook MARIE Allbrook			2a. DATE OF DEATH MONTH DAY YEAR 2-4-82		2b. HOUR 9 P.M.
3. SEX Female	4. RACE black	5. DATE OF BIRTH MONTH DAY YEAR 12 20 30		6. AGE (IN YEARS LAST BIRTHDAY) 51 YRS.	IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland	7b. CITIZEN OF WHAT COUNTRY? USA	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City MD.		
10. CITY OR TOWN OF DEATH Baltimore	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) University of Maryland		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY
13a. STATE MD	13b. COUNTY	13c. CITY OR TOWN BALTIMORE	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET ADDRESS 1607 W. Mulberry St.	
14. FATHER'S NAME FIRST MIDDLE LAST Andrew		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST marie			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) NO		16b. SOCIAL SECURITY NO. N/A		17. INFORMANT ADDRESS Gloria Benjamin 701 Beaumont Ave	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Cardiopulmonary Arrest 1991 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Sepsis DUE TO, OR AS A CONSEQUENCE OF (c) widely metastatic Cancer					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 10 min one week 10 years
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from 1-26 , 19 82 , to 2-4 , 19 82 , that (I) (we) lost saw the deceased alive on 2-4 , 19 82 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE Janet Todarczuk MD DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>				22c. DATE SIGNED 2-4-82	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) JANET TODARCZUK			22e. ADDRESS 22 S. Greene St Balto MD		
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 2/10/82		23c. NAME OF CEMETERY OR CREMATORY king mem. Ph.	
23d. LOCATION CITY OR TOWN Balto.		23e. COUNTY Baltimore		23f. STATE Md	
24. FUNERAL DIRECTOR NAME Wm. C. March F/H			ADDRESS 1101 E. North Ave		25a. DATE REC'D. BY REGISTRAR FEB 9 1982
			25b. REGISTRAR Frances Jan Nathan		

11

ONE

x

MD

Adrian

on

Baltimore &

Paris

Paris

via

Glenn Goodman for

1005 St. Lawrence St

Handwritten notes at the bottom of the page, including "March 1977" and "H3" and "H4".

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be contacted.

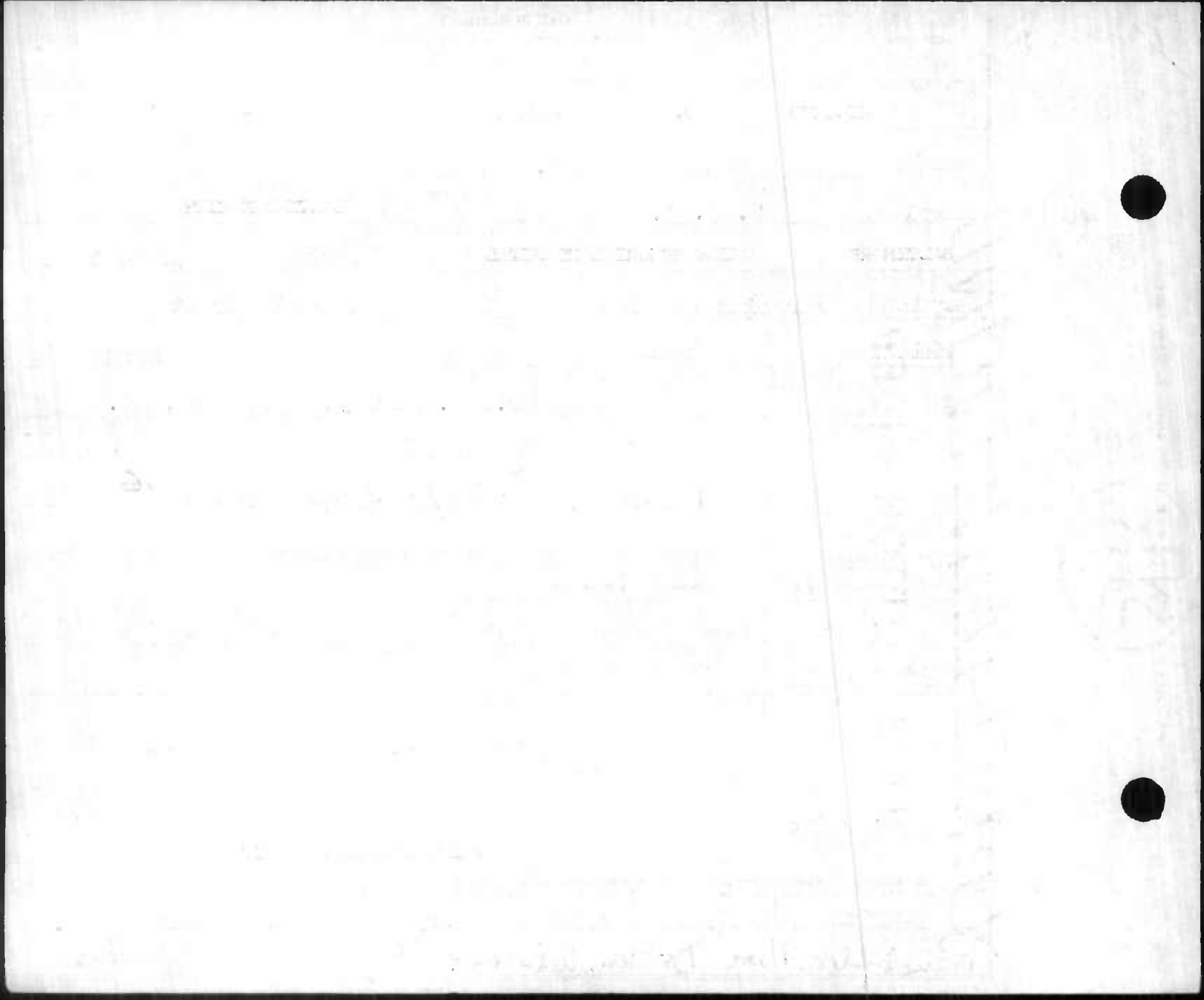
STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 2 0 3 5 0 0

REG. NO.

1. FOR STATE REGISTRAR		2a. DATE OF DEATH		MONTH	DAY	YEAR	2b. HOUR
1. DECEASED NAME (TYPE OR PRINT)		2. DATE OF DEATH		MONTH	DAY	YEAR	2b. HOUR
MILDRED D. ALSTROM		2		14	82	2 45	A.M.
3. SEX	4. RACE	5. DATE OF BIRTH	6. AGE (IN YEARS LAST BIRTHDAY)	IF UNDER 1 YEAR		IF UNDER 24 HRS	
Female	Caucasian	Oct. 11, 1901	80	YRS.			
7. BIRTHPLACE (STATE OR FOREIGN COUNTRY)	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH				
Maryland	U. S. A.		BALTIMORE CITY MD.				
10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)	12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY			
BALTIMORE	UNION MEMORIAL HOSPITAL	Teacher		Education			
13a. STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS?	13e. STREET ADDRESS			
Maryland	Caroline	Denton	YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	Market Street			
14. FATHER'S NAME	15. MOTHER'S MAIDEN NAME	16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)					
Phillip Downes	Mary Johnson	16b. SOCIAL SECURITY NO.					
		17. INFORMANT ADDRESS					
		Mrs. E. Murray, Baltimore, Md.					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY:							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
IMMEDIATE CAUSE (a) <u>Cardiovascular arrest</u>							4-6 min.
5698 DUE TO, OR AS A CONSEQUENCE OF							16 days
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.							
(b) <u>Perf. & sigmoid colon / S/P sigmoid colon</u>							
DUE TO, OR AS A CONSEQUENCE OF							
(c)							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION, GIVEN IN PART 1(a):							
<u>Cardiac failure, renal failure</u>							
19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY?	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?				
1/29/82	Perf. & sigmoid & acute pancreatitis	YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	YES <input type="checkbox"/> NO <input type="checkbox"/>				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
	HOUR A.M. MONTH DAY YEAR						
	P.M. 19						
21d. INJURY OCCURRED	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION					
WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from 1/21, 19 82, to 2/14, 19 82, that (I) (we) last saw the deceased alive on 2/14, 19 82, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE		DEGREE		22c. DATE SIGNED			
D. Murray, M.D.				2/14/82			
22d. PHYSICIAN'S NAME (TYPE OR PRINT)		22e. ADDRESS					
		UNION MEMORIAL HOSPITAL					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION				
Burial	2/17/82	Denton Cemetery	CITY OR TOWN COUNTY STATE				
			Denton Caroline Md.				
24. FUNERAL DIRECTOR		25. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE			
NAME ADDRESS		FEB 19 1982		James J. [Signature]			
Randolph P. Moore Denton, Md 21620							

BP



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 2 0 3 5 0 1

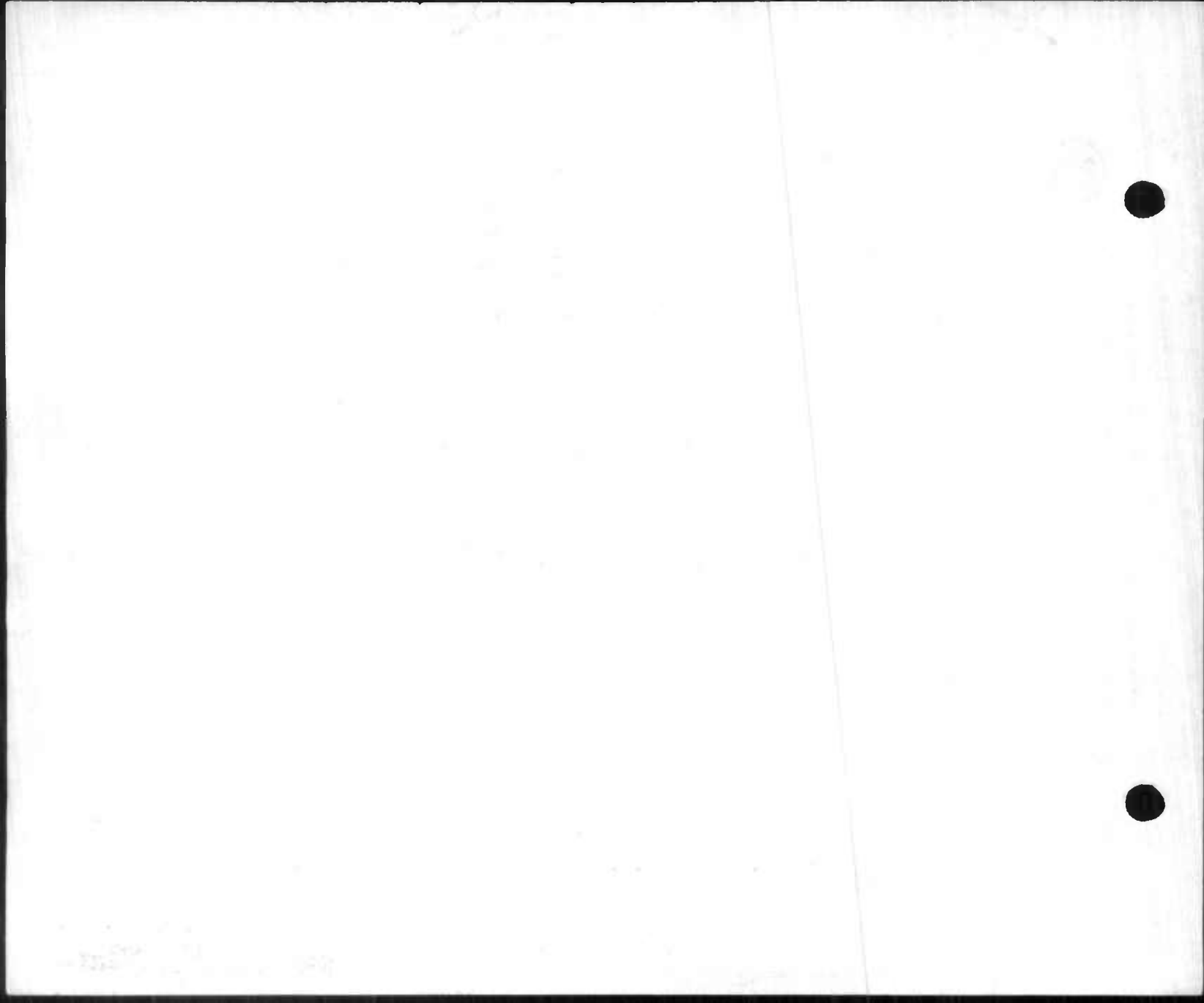
REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Alberta Anderson			2a. DATE OF DEATH MONTH DAY YEAR 2 6 1982		2b. HOUR M M
3. SEX female	4. RACE black	5. DATE OF BIRTH MONTH DAY YEAR 10 31 1921		6. AGE (IN YEARS LAST BIRTHDAY) YRS. 60	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Va	7b. CITIZEN OF WHAT COUNTRY? USA	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore city MD	
10. CITY OR TOWN OF DEATH Baltimore		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN HOME FACILITY, GIVE STREET ADDRESS) 1232 Darley Avenue		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)	
12b. KIND OF BUSINESS OR INDUSTRY					
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)					
13a. STATE Ma	13b. COUNTY Baltimore	13c. CITY OR TOWN Baltimore	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET ADDRESS 1232 Darley Avenue	
14. FATHER'S NAME FIRST MIDDLE LAST Samuel White		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Grace Robinson			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) No		16b. SOCIAL SECURITY NO. N/A		17. INFORMANT ADDRESS Alpheus White 1232 Darley Avenue	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: 4360 IMMEDIATE CAUSE (a) Cardiac arrest DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) STROKE DUE TO, OR AS A CONSEQUENCE OF (c)					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			
21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from 9 19 81 to 1 19 82 , that (I) (we) last saw the deceased alive on 1/15 19 82 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE W Balke		DEGREE BALKE		22c. DATE SIGNED 2/8/82	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) BALKE		22e. ADDRESS John Hall			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 2/11/82		23c. NAME OF CEMETERY OR CREMATORY Garden of Eternal	
23d. LOCATION CITY OR TOWN Westminster		23e. COUNTY MD			
24. FUNERAL DIRECTOR NAME William C. March F/H 1101 E. North Avenue		24b. ADDRESS 1101 E. North Avenue			
24c. DATE REC'D. BY REGISTRAR FEB 9 1982		24d. REGISTRAR James J. Nathan			

199 2839

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 IN YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 24 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH										REG. NO. 03502					
1- FOR STATE REGISTRAR										2a. DATE KNOWN OF DEATH ESTIMATED		2b. HOUR			
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST CARRIE W. ANDERSON										MONTH DAY YEAR 2 5 19 82		M			
3. SEX female		4. RACE negro		5. DATE OF BIRTH MONTH DAY YEAR 12 12 02		6. AGE (IN YEARS LAST BIRTHDAY) 79 YRS.		IF UNDER 1 YR. MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.		7c. DATE PRONOUNCED DEAD MONTH DAY YEAR 2 5 19 82		24 HOUR 2:15 PM	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Ga.				7b. CITIZEN OF WHAT COUNTRY? USA				8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>				9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City MD.			
10. CITY OR TOWN OF DEATH Baltimore				11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Provident Hospital						12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)				12b. KIND OF BUSINESS OR INDUSTRY	
USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)															
13a. STATE Md				13b. COUNTY		13c. CITY OR TOWN Baltimore		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 2128 N. Pulaski Street					
14. FATHER'S NAME FIRST MIDDLE LAST Abraham Wilson						15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Charlotte Williams									
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) No				16b. SOCIAL SECURITY NO. N/A				17. INFORMANT ADDRESS Ralph Anderson 2128 N. Pulaski St							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: 4029 IMMEDIATE CAUSE (a) <u>Hypertensive & arteriosclerotic cardiovascular disease</u> Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause lost: (b) _____ (c) _____ DUE TO, OR AS A CONSEQUENCE OF DUE TO, OR AS A CONSEQUENCE OF APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH															
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)															
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?								20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19				21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)				21f. LOCATION STREET CITY OR TOWN COUNTY STATE							
22a. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> .															
ACTUAL SIGNATURE <i>Ann M. Dixon</i>						TITLE (SPECIFY) Assistant MEDICAL EXAMINER						DATE SIGNED 2-6-82			
EXAMINER'S NAME (TYPE OR PRINT) Ann M. Dixon, M.D.						ADDRESS 111 Penn St.									
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial				23b. DATE 2/9/82		23c. NAME OF CEMETERY OR CREMATORY King Mem Park				23d. LOCATION CITY OR TOWN COUNTY STATE Balto Co Md					
24. FUNERAL DIRECTOR NAME ADDRESS William C. March F/H 1101 E. North Ave						25a. DATE REC'D. BY REGISTRAR FEB 9 1982				25b. REGISTRAR'S SIGNATURE <i>Frances Jan Nethen</i>					



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Post-mortem examinations are not required.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 2 0 3 5 0 3

FOR
1- STATE
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) James J. ANTHONY			2a. DATE OF DEATH February 10, 1982			2b. HOUR 12:05 a			
3. SEX Male		4. RACE Black		5. DATE OF BIRTH 9 7 1915		6. AGE (IN YEARS (LAST BIRTHDAY)) 66 YRS.		7. IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) North Carolina		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City MD.			
10. CITY OR TOWN OF DEATH Baltimore		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Maryland General Hospital				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Stock-Clerk		12b. KIND OF BUSINESS OR INDUSTRY Education	
13a. STATE Maryland		13b. COUNTY		13c. CITY OR TOWN Baltimore		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
14. FATHER'S NAME George		15. MOTHER'S MAIDEN NAME Anna		16. SOCIAL SECURITY NO. 237-05-6439A					
17. INFORMANT Mrs. Mary F. Smith		18. ADDRESS Baltimore Maryland 21216 2704 Winchester St							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Renal failure 2500 DUE TO, OR AS A CONSEQUENCE OF (b) Sepsis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) Diabetes Mellitus DUE TO, OR AS A CONSEQUENCE OF PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from January 29, 1982, to February 10, 1982, that (I) (we) last saw the deceased alive on February 10, 1982, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) did (do) view the body after death.									
22b. SIGNATURE Susan Siegel MD		DEGREE MD		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		22c. DATE SIGNED 2/10/82			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Susan Siegel, M.D.		22e. ADDRESS c/o Maryland General Hospital							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 2/15/82		23c. NAME OF CEMETERY OR CREMATORY St. James Ch. Cem.		23d. LOCATION CITY OR TOWN COUNTY STATE Lincoln County, N.C.			
24. FUNERAL DIRECTOR NAME Herbert E. Nutter		ADDRESS BALTIMORE MARYLAND 21216 Funeral Home 335 W. North Ave.		25a. DATE REC'D. BY REGISTRAR FEB 16 1982		25b. REGISTRAR'S SIGNATURE [Signature]			

11

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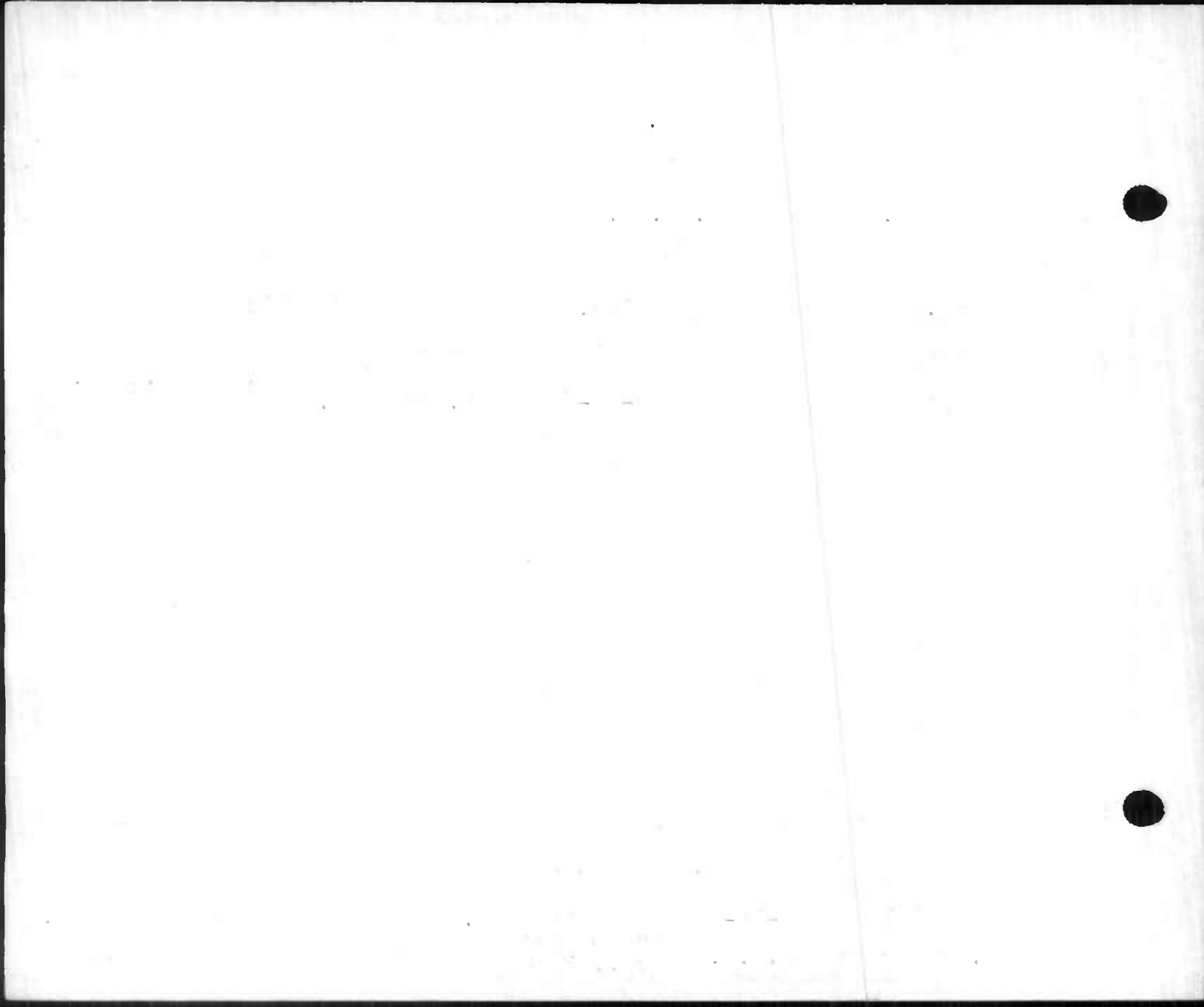
Barryland General Central

Barryland General Central

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, 3, 4, 5, 6, 7, 8, 9, 10, 11, 12, 13, 14, 15, 16, 17, 18, 19, 20, 21, 22, 23, 24, 25, 26, 27, 28, 29, 30, 31, 32, 33, 34, 35, 36, 37, 38, 39, 40, 41, 42, 43, 44, 45, 46, 47, 48, 49, 50, 51, 52, 53, 54, 55, 56, 57, 58, 59, 60, 61, 62, 63, 64, 65, 66, 67, 68, 69, 70, 71, 72, 73, 74, 75, 76, 77, 78, 79, 80, 81, 82, 83, 84, 85, 86, 87, 88, 89, 90, 91, 92, 93, 94, 95, 96, 97, 98, 99, 100, 101, 102, 103, 104, 105, 106, 107, 108, 109, 110, 111, 112, 113, 114, 115, 116, 117, 118, 119, 120, 121, 122, 123, 124, 125, 126, 127, 128, 129, 130, 131, 132, 133, 134, 135, 136, 137, 138, 139, 140, 141, 142, 143, 144, 145, 146, 147, 148, 149, 150, 151, 152, 153, 154, 155, 156, 157, 158, 159, 160, 161, 162, 163, 164, 165, 166, 167, 168, 169, 170, 171, 172, 173, 174, 175, 176, 177, 178, 179, 180, 181, 182, 183, 184, 185, 186, 187, 188, 189, 190, 191, 192, 193, 194, 195, 196, 197, 198, 199, 200, 201, 202, 203, 204, 205, 206, 207, 208, 209, 210, 211, 212, 213, 214, 215, 216, 217, 218, 219, 220, 221, 222, 223, 224, 225, 226, 227, 228, 229, 230, 231, 232, 233, 234, 235, 236, 237, 238, 239, 240, 241, 242, 243, 244, 245, 246, 247, 248, 249, 250, 251, 252, 253, 254, 255, 256, 257, 258, 259, 260, 261, 262, 263, 264, 265, 266, 267, 268, 269, 270, 271, 272, 273, 274, 275, 276, 277, 278, 279, 280, 281, 282, 283, 284, 285, 286, 287, 288, 289, 290, 291, 292, 293, 294, 295, 296, 297, 298, 299, 300, 301, 302, 303, 304, 305, 306, 307, 308, 309, 310, 311, 312, 313, 314, 315, 316, 317, 318, 319, 320, 321, 322, 323, 324, 325, 326, 327, 328, 329, 330, 331, 332, 333, 334, 335, 336, 337, 338, 339, 340, 341, 342, 343, 344, 345, 346, 347, 348, 349, 350, 351, 352, 353, 354, 355, 356, 357, 358, 359, 360, 361, 362, 363, 364, 365, 366, 367, 368, 369, 370, 371, 372, 373, 374, 375, 376, 377, 378, 379, 380, 381, 382, 383, 384, 385, 386, 387, 388, 389, 390, 391, 392, 393, 394, 395, 396, 397, 398, 399, 400, 401, 402, 403, 404, 405, 406, 407, 408, 409, 410, 411, 412, 413, 414, 415, 416, 417, 418, 419, 420, 421, 422, 423, 424, 425, 426, 427, 428, 429, 430, 431, 432, 433, 434, 435, 436, 437, 438, 439, 440, 441, 442, 443, 444, 445, 446, 447, 448, 449, 450, 451, 452, 453, 454, 455, 456, 457, 458, 459, 460, 461, 462, 463, 464, 465, 466, 467, 468, 469, 470, 471, 472, 473, 474, 475, 476, 477, 478, 479, 480, 481, 482, 483, 484, 485, 486, 487, 488, 489, 490, 491, 492, 493, 494, 495, 496, 497, 498, 499, 500, 501, 502, 503, 504, 505, 506, 507, 508, 509, 510, 511, 512, 513, 514, 515, 516, 517, 518, 519, 520, 521, 522, 523, 524, 525, 526, 527, 528, 529, 530, 531, 532, 533, 534, 535, 536, 537, 538, 539, 540, 541, 542, 543, 544, 545, 546, 547, 548, 549, 550, 551, 552, 553, 554, 555, 556, 557, 558, 559, 560, 561, 562, 563, 564, 565, 566, 567, 568, 569, 570, 571, 572, 573, 574, 575, 576, 577, 578, 579, 580, 581, 582, 583, 584, 585, 586, 587, 588, 589, 590, 591, 592, 593, 594, 595, 596, 597, 598, 599, 600, 601, 602, 603, 604, 605, 606, 607, 608, 609, 610, 611, 612, 613, 614, 615, 616, 617, 618, 619, 620, 621, 622, 623, 624, 625, 626, 627, 628, 629, 630, 631, 632, 633, 634, 635, 636, 637, 638, 639, 640, 641, 642, 643, 644, 645, 646, 647, 648, 649, 650, 651, 652, 653, 654, 655, 656, 657, 658, 659, 660, 661, 662, 663, 664, 665, 666, 667, 668, 669, 670, 671, 672, 673, 674, 675, 676, 677, 678, 679, 680, 681, 682, 683, 684, 685, 686, 687, 688, 689, 690, 691, 692, 693, 694, 695, 696, 697, 698, 699, 700, 701, 702, 703, 704, 705, 706, 707, 708, 709, 710, 711, 712, 713, 714, 715, 716, 717, 718, 719, 720, 721, 722, 723, 724, 725, 726, 727, 728, 729, 730, 731, 732, 733, 734, 735, 736, 737, 738, 739, 740, 741, 742, 743, 744, 745, 746, 747, 748, 749, 750, 751, 752, 753, 754, 755, 756, 757, 758, 759, 760, 761, 762, 763, 764, 765, 766, 767, 768, 769, 770, 771, 772, 773, 774, 775, 776, 777, 778, 779, 780, 781, 782, 783, 784, 785, 786, 787, 788, 789, 790, 791, 792, 793, 794, 795, 796, 797, 798, 799, 800, 801, 802, 803, 804, 805, 806, 807, 808, 809, 810, 811, 812, 813, 814, 815, 816, 817, 818, 819, 820, 821, 822, 823, 824, 825, 826, 827, 828, 829, 830, 831, 832, 833, 834, 835, 836, 837, 838, 839, 840, 841, 842, 843, 844, 845, 846, 847, 848, 849, 850, 851, 852, 853, 854, 855, 856, 857, 858, 859, 860, 861, 862, 863, 864, 865, 866, 867, 868, 869, 870, 871, 872, 873, 874, 875, 876, 877, 878, 879, 880, 881, 882, 883, 884, 885, 886, 887, 888, 889, 890, 891, 892, 893, 894, 895, 896, 897, 898, 899, 900, 901, 902, 903, 904, 905, 906, 907, 908, 909, 910, 911, 912, 913, 914, 915, 916, 917, 918, 919, 920, 921, 922, 923, 924, 925, 926, 927, 928, 929, 930, 931, 932, 933, 934, 935, 936, 937, 938, 939, 940, 941, 942, 943, 944, 945, 946, 947, 948, 949, 950, 951, 952, 953, 954, 955, 956, 957, 958, 959, 960, 961, 962, 963, 964, 965, 966, 967, 968, 969, 970, 971, 972, 973, 974, 975, 976, 977, 978, 979, 980, 981, 982, 983, 984, 985, 986, 987, 988, 989, 990, 991, 992, 993, 994, 995, 996, 997, 998, 999, 1000.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH										REG. NO. 2 0 3 5 0 4	
1- FOR REGISTRAR											
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Matilda H. Anton										2a. DATE KNOWN OF DEATH ESTIMATED <input checked="" type="checkbox"/> MONTH DAY YEAR 2 15 19 82	
3. SEX Female		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR 8 3 1899 82 YRS.		6. AGE (IN YEARS LAST BIRTHDAY) MONTHS DAYS HOURS MIN.		7c. DATE PRONOUNCED DEAD 2 15 19 82		24. HOUR 2:39 P.M.	
2b. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Md.				7b. CITIZEN OF WHAT COUNTRY? U. S. A.				8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City, MD	
10. CITY OR TOWN OF DEATH Baltimore				11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 345 Yale Avenue				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Housewife		12b. KIND OF BUSINESS OR INDUSTRY	
USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)											
13a. STATE Md.		13b. COUNTY		13c. CITY OR TOWN Balto.		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 345 Yale Avenue			
14. FATHER'S NAME FIRST MIDDLE LAST Jacob Keuler				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Matilda Nussman							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) No				16b. SOCIAL SECURITY NO. 220-09-6469				17. INFORMANT ADDRESS Mrs. Frieda A. Maylee 4406 Ridge Ave., Balto., Md.		21227	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 4292 Arteriosclerotic Cardiovascular Disease DUE TO, OR AS A CONSEQUENCE OF (b) DUE TO, OR AS A CONSEQUENCE OF (c)										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)											
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?						20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19				21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)				21f. LOCATION CITY OR TOWN COUNTY STATE			
22a. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> .											
ACTUAL SIGNATURE Virginia L. Dolan						TITLE (SPECIFY) Assistant		MEDICAL EXAMINER		DATE SIGNED 2-16-82	
EXAMINER'S NAME (TYPE OR PRINT) Virginia L. Dolan, M.D.						ADDRESS 111 Penn Street					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial				23b. DATE 2-18-82		23c. NAME OF CEMETERY OR CREMATORY Lake View Mem. Park				23d. LOCATION CITY OR TOWN COUNTY STATE Sykesville Md.	
24. FUNERAL DIRECTOR G. Truman Schwab, P.A.						ADDRESS 3512 Frederick Ave., 21229		25a. DATE REC'D. BY REGISTRAR FEB 22 1982		25b. REGISTRAR'S SIGNATURE	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				REG. NO. 8203505			
1. FOR STATE REGISTRAR				2a. DATE OF DEATH MONTH DAY YEAR			
1 DECEASED NAME FIRST MIDDLE LAST LEO APPLE				FEBRUARY 12, 1982			
3 SEX MALE		4 RACE CAUCASIAN		5 DATE OF BIRTH MONTH DAY YEAR JAN. 27, 1900		6 AGE (IN YEARS LAST BIRTHDAY) 82 YRS.	
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) MARYLAND		7b CITIZEN OF WHAT COUNTRY? U.S.A.		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE CITY MD.	
10 CITY OR TOWN OF DEATH BALTIMORE		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 3708 CLARKS LANE		12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) CLERK		12b KIND OF BUSINESS OR INDUSTRY CITY OF BALTO.	
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)				13d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
13a STATE MARYLAND		13b COUNTY		13c CITY OR TOWN BALTIMORE		13e STREET ADDRESS 3708 CLARKS LANE (21215)	
14 FATHER'S NAME FIRST MIDDLE LAST UNKNOWN APPLE				15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST KATIE UNKNOWN			
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO		16b SOCIAL SECURITY NO.		17 INFORMANT ADDRESS MR. KARL APPLE 3708 CLARKS LA. (21215)			
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY 4100 IMMEDIATE CAUSE (a) <u>Acute myocardial Infarction</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>arteriosclerotic Heart Disease</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>none</u>							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 1 day 10 years
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a): <u>none</u>							
19a DATE OF OPERATION		19b CONDITION FOR WHICH OPERATION WAS PERFORMED		20a AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f LOCATION STREET CITY OR TOWN COUNTY STATE			
22a I certify that (I) (this hospital) attended the deceased from <u>Nov 27</u> 19 <u>69</u> , to <u>Feb 12</u> 19 <u>82</u> , that (I) (we) last saw the deceased alive on <u>Feb 6</u> 19 <u>82</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did not) view the body after death.							
22b SIGNATURE Manuel Levin M.D.				DEGREE M.D.		22c DATE SIGNED 2/13/82	
22d PHYSICIAN'S NAME (TYPE OR PRINT) MANUEL LEVIN M.D.				22e ADDRESS 6101 PK HTS AVE BALTO MD 21215			
23a BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL		23b DATE FEB 14/82		23c NAME OF CEMETERY OR CREMATORY ONEB SHALOM		23d LOCATION CITY OR TOWN COUNTY STATE BALTIMORE, MD	
24 FUNERAL DIRECTOR NAME Sok Levinson & Bros - 6010 Reisterstown Rd				25a DATE REC'D. BY REGISTRAR FEB 17 1982			

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. It may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										REG. NO.	
1- FOR STATE REGISTRAR			1 DECEASED NAME (TYPE OR PRINT) RAYMOND B ARMACOST, JR				2a DATE OF DEATH MONTH DAY YEAR 2 23 82			2b HOUR 1:05A	
3 SEX Male		4 RACE White		5 DATE OF BIRTH MONTH DAY YEAR 4 7 45		6 AGE (IN YEARS LAST BIRTHDAY) 36 YRS.		IF UNDER 1 YEAR MONTHS DAYS 0 0		IF UNDER 24 HRS. HOURS MIN. 0 0	
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b CITIZEN OF WHAT COUNTRY? USA		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City MD.					
10 CITY OR TOWN OF DEATH Baltimore		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) St. Agnes Hospital				12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) None			12b KIND OF BUSINESS OR INDUSTRY		
13a STATE Maryland			13b COUNTY Baltimore		13c CITY OR TOWN Catonsville		13d INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e STREET ADDRESS 6029 Chesworth Road		
14 FATHER'S NAME FIRST MIDDLE LAST Raymond B. Armacost, Sr.						15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST J. Norma Pence					
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) Yes			16b SOCIAL SECURITY NO. Vietnam		17 INFORMANT ADDRESS Raymond B. Armacost, Sr. Same as #13						
18 CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) SEVERE PULMONARY CONGESTION & EDEMA 4239 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) SEVERE PERICARDITIS DUE TO, OR AS A CONSEQUENCE OF (c) ?										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH DAYS	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)											
19a DATE OF OPERATION			19b CONDITION FOR WHICH OPERATION WAS PERFORMED				20a AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)			21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR 19 P.M.		21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)						
21d INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			21e PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f LOCATION STREET CITY OR TOWN COUNTY STATE						
22a I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) lost saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b SIGNATURE James E Taylor						DEGREE M.D.		ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		22c DATE SIGNED 2/23/82	
22d PHYSICIAN'S NAME (TYPE OR PRINT) JAMES E. TAYLOR						22e ADDRESS ST AGNES HOSPITAL					
23a BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b DATE 2/26/82		23c NAME OF CEMETERY OR CREMATORY New Cathedral Cem.			23d LOCATION CITY OR TOWN COUNTY STATE Baltimore Md.			
24 FUNERAL DIRECTOR NAME Witzke P.A.						25a DATE REC'D. BY REGISTRAR 2/25 1982		25b REGISTRAR'S SIGNATURE Frances Jan Wither			
1630 Edmondson Ave, Catonsville, Md.											

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TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, THE EXAMINER SHOULD WRITE "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. GIVE PAGE 4 TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED. AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

1- FOR
STATE
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT)			2a. DATE KNOWN OF DEATH			2b. DATE ESTIMATED			2c. DATE PRONOUNCED DEAD			2d. DATE OF DEATH			2e. DATE OF DEATH			2f. DATE OF DEATH			2g. DATE OF DEATH			2h. DATE OF DEATH			2i. DATE OF DEATH			2j. DATE OF DEATH			2k. DATE OF DEATH			2l. DATE OF DEATH			2m. DATE OF DEATH			2n. DATE OF DEATH			2o. DATE OF DEATH			2p. DATE OF DEATH			2q. DATE OF DEATH			2r. DATE OF DEATH			2s. DATE OF DEATH			2t. DATE OF DEATH			2u. DATE OF DEATH			2v. DATE OF DEATH			2w. DATE OF DEATH			2x. DATE OF DEATH			2y. DATE OF DEATH			2z. DATE OF DEATH																																																																																																																																																																							
Charles G Armiger			20. DATE KNOWN OF DEATH XX MONTH DAY YEAR 2 16 19 82			21. DATE ESTIMATED MONTH DAY YEAR 2 16 19 82			22. DATE PRONOUNCED DEAD MONTH DAY YEAR 2 16 19 82			23. DATE OF DEATH MONTH DAY YEAR 2 16 19 82			24. DATE OF DEATH MONTH DAY YEAR 2 16 19 82			25. DATE OF DEATH MONTH DAY YEAR 2 16 19 82			26. DATE OF DEATH MONTH DAY YEAR 2 16 19 82			27. DATE OF DEATH MONTH DAY YEAR 2 16 19 82			28. DATE OF DEATH MONTH DAY YEAR 2 16 19 82			29. DATE OF DEATH MONTH DAY YEAR 2 16 19 82			30. DATE OF DEATH MONTH DAY YEAR 2 16 19 82			31. DATE OF DEATH MONTH DAY YEAR 2 16 19 82			32. DATE OF DEATH MONTH DAY YEAR 2 16 19 82			33. DATE OF DEATH MONTH DAY YEAR 2 16 19 82			34. DATE OF DEATH MONTH DAY YEAR 2 16 19 82			35. DATE OF DEATH MONTH DAY YEAR 2 16 19 82			36. DATE OF DEATH MONTH DAY YEAR 2 16 19 82			37. DATE OF DEATH MONTH DAY YEAR 2 16 19 82			38. DATE OF DEATH MONTH DAY YEAR 2 16 19 82			39. DATE OF DEATH MONTH DAY YEAR 2 16 19 82			40. DATE OF DEATH MONTH DAY YEAR 2 16 19 82			41. DATE OF DEATH MONTH DAY YEAR 2 16 19 82			42. DATE OF DEATH MONTH DAY YEAR 2 16 19 82			43. DATE OF DEATH MONTH DAY YEAR 2 16 19 82			44. DATE OF DEATH MONTH DAY YEAR 2 16 19 82			45. DATE OF DEATH MONTH DAY YEAR 2 16 19 82			46. DATE OF DEATH MONTH DAY YEAR 2 16 19 82			47. DATE OF DEATH MONTH DAY YEAR 2 16 19 82			48. DATE OF DEATH MONTH DAY YEAR 2 16 19 82			49. DATE OF DEATH MONTH DAY YEAR 2 16 19 82			50. DATE OF DEATH MONTH DAY YEAR 2 16 19 82			51. DATE OF DEATH MONTH DAY YEAR 2 16 19 82			52. DATE OF DEATH MONTH DAY YEAR 2 16 19 82			53. DATE OF DEATH MONTH DAY YEAR 2 16 19 82			54. DATE OF DEATH MONTH DAY YEAR 2 16 19 82			55. DATE OF DEATH MONTH DAY YEAR 2 16 19 82			56. DATE OF DEATH MONTH DAY YEAR 2 16 19 82			57. DATE OF DEATH MONTH DAY YEAR 2 16 19 82			58. DATE OF DEATH MONTH DAY YEAR 2 16 19 82			59. DATE OF DEATH MONTH DAY YEAR 2 16 19 82			60. DATE OF DEATH MONTH DAY YEAR 2 16 19 82			61. DATE OF DEATH MONTH DAY YEAR 2 16 19 82			62. DATE OF DEATH MONTH DAY YEAR 2 16 19 82			63. DATE OF DEATH MONTH DAY YEAR 2 16 19 82			64. DATE OF DEATH MONTH DAY YEAR 2 16 19 82			65. DATE OF DEATH MONTH DAY YEAR 2 16 19 82			66. DATE OF DEATH MONTH DAY YEAR 2 16 19 82			67. DATE OF DEATH MONTH DAY YEAR 2 16 19 82			68. DATE OF DEATH MONTH DAY YEAR 2 16 19 82			69. DATE OF DEATH MONTH DAY YEAR 2 16 19 82			70. DATE OF DEATH MONTH DAY YEAR 2 16 19 82			71. DATE OF DEATH MONTH DAY YEAR 2 16 19 82			72. DATE OF DEATH MONTH DAY YEAR 2 16 19 82			73. DATE OF DEATH MONTH DAY YEAR 2 16 19 82			74. DATE OF DEATH MONTH DAY YEAR 2 16 19 82			75. DATE OF DEATH MONTH DAY YEAR 2 16 19 82			76. DATE OF DEATH MONTH DAY YEAR 2 16 19 82			77. DATE OF DEATH MONTH DAY YEAR 2 16 19 82			78. DATE OF DEATH MONTH DAY YEAR 2 16 19 82			79. DATE OF DEATH MONTH DAY YEAR 2 16 19 82			80. DATE OF DEATH MONTH DAY YEAR 2 16 19 82			81. DATE OF DEATH MONTH DAY YEAR 2 16 19 82			82. DATE OF DEATH MONTH DAY YEAR 2 16 19 82			83. DATE OF DEATH MONTH DAY YEAR 2 16 19 82			84. DATE OF DEATH MONTH DAY YEAR 2 16 19 82			85. DATE OF DEATH MONTH DAY YEAR 2 16 19 82			86. DATE OF DEATH MONTH DAY YEAR 2 16 19 82			87. DATE OF DEATH MONTH DAY YEAR 2 16 19 82			88. DATE OF DEATH MONTH DAY YEAR 2 16 19 82			89. DATE OF DEATH MONTH DAY YEAR 2 16 19 82			90. DATE OF DEATH MONTH DAY YEAR 2 16 19 82			91. DATE OF DEATH MONTH DAY YEAR 2 16 19 82			92. DATE OF DEATH MONTH DAY YEAR 2 16 19 82			93. DATE OF DEATH MONTH DAY YEAR 2 16 19 82			94. DATE OF DEATH MONTH DAY YEAR 2 16 19 82			95. DATE OF DEATH MONTH DAY YEAR 2 16 19 82			96. DATE OF DEATH MONTH DAY YEAR 2 16 19 82			97. DATE OF DEATH MONTH DAY YEAR 2 16 19 82			98. DATE OF DEATH MONTH DAY YEAR 2 16 19 82			99. DATE OF DEATH MONTH DAY YEAR 2 16 19 82			100. DATE OF DEATH MONTH DAY YEAR 2 16 19 82		
3. SEX male			4. RACE white			5. DATE OF BIRTH MONTH DAY YEAR 9 29 55			6. AGE (IN YEARS) (LAST BIRTHDAY) 26 YRS.			7. IF UNDER 1 YR. MONTHS DAYS			8. IF UNDER 24 HRS. HOURS MIN.			9. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland			10. CITIZEN OF WHAT COUNTRY? USA			11. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			12. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City			13. CITY OR TOWN OF DEATH Baltimore			14. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) St. Agnes Hospital			15. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Electrician			16. KIND OF BUSINESS OR INDUSTRY Wesinghouse			17. USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) STATE COUNTY Maryland Baltimore			18. CITY OR TOWN Baltimore			19. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			20. STREET ADDRESS 508 S. 47 th Street			21. FATHER'S NAME FIRST MIDDLE LAST George Armiger			22. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Sara Nichols			23. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) no			24. SOCIAL SECURITY NO. 214 64 8959			25. INFORMANT Mary Armiger			26. ADDRESS 508 S. 47 th Street			27. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Electrocution</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.</u> (c) <u>9252</u>			28. APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			29. PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a).			30. DATE OF OPERATION			31. CONDITION FOR WHICH OPERATION WAS PERFORMED?			32. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			33. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH			34. TIME OF INJURY HOUR A.M. MONTH DAY YEAR 1:42 P.M. 2/16 19 82			35. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2) installing an electrical fixture			36. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) building			37. LOCATION STREET CITY OR TOWN STATE WestinghouseWatersonRd&NurseryLa, Linthicum, MD			38. I certify that I took charge of the remains described above, held on death resulted from <u>Accident</u> <input checked="" type="checkbox"/> <u>Autopsy</u> <input checked="" type="checkbox"/> <u>Inspection</u> <input type="checkbox"/> <u>Inquiry</u> <input type="checkbox"/> and in my opinion <u>Accident</u> <input checked="" type="checkbox"/> <u>Suicide</u> <input type="checkbox"/> <u>Homicide</u> <input type="checkbox"/> <u>Undetermined manner</u> <input type="checkbox"/>			39. ACTUAL SIGNATURE <u>H.R. Guard</u>			40. TITLE (SPECIFY) Assistant			41. MEDICAL EXAMINER			42. DATE SIGNED 2/17/82			43. EXAMINER'S NAME (TYPE OR PRINT) Hormez R. Guard, M.D.			44. ADDRESS 111 Penn Street, Balto. MD 21201			45. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			46. DATE 2/20/82			47. NAME OF CEMETERY OR CREMATORY Oak Lawn			48. LOCATION CITY OR TOWN COUNTY STATE Baltimore Md			49. FUNERAL DIRECTOR NAME Walter Dabrowski			50. ADDRESS 1005 Dundalk Avenue			51. DATE REC'D. BY REGISTRAR FEB 24 1982			52. REGISTRAR'S SIGNATURE <u>James J. Nathan</u>																																																																																																		

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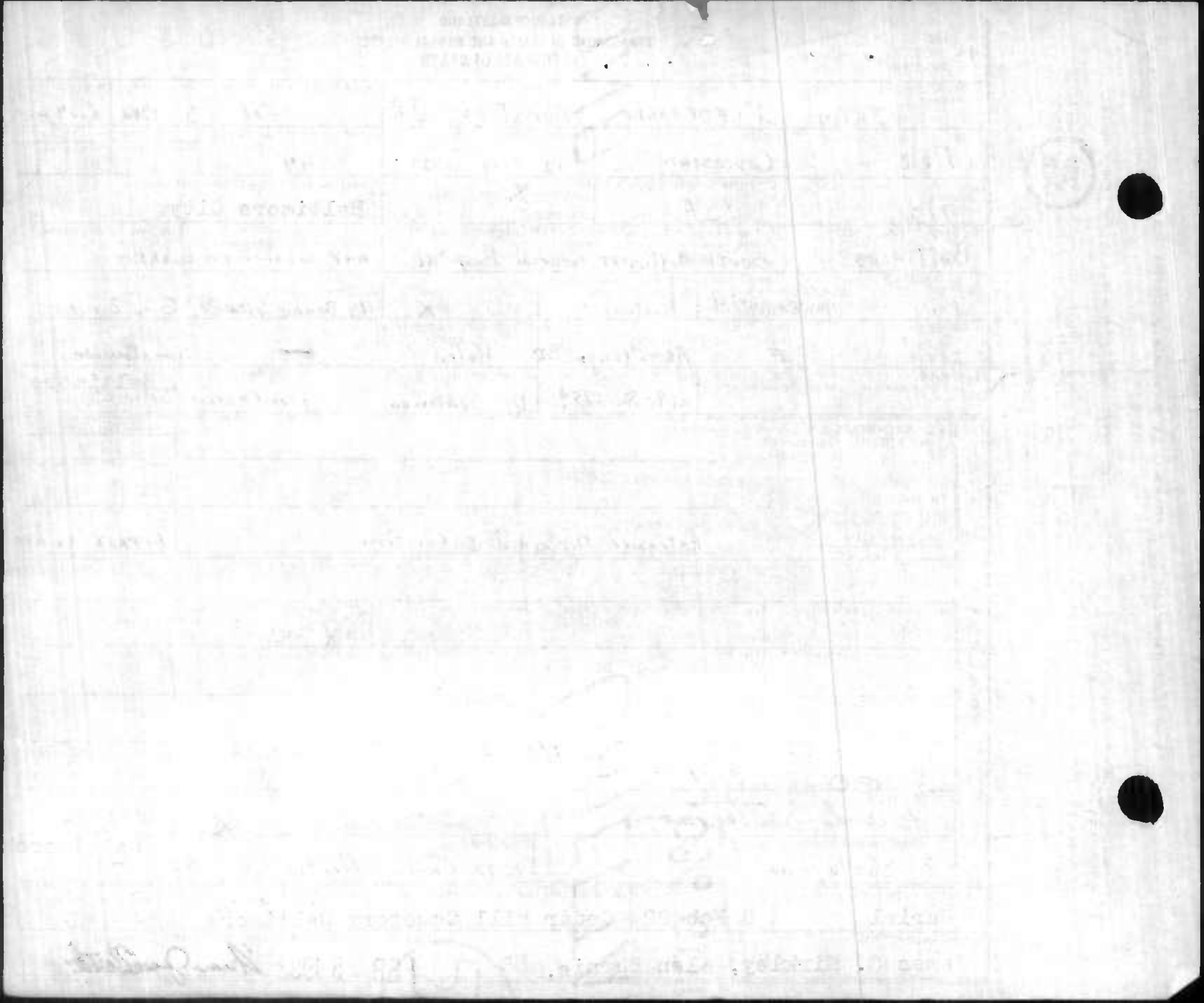
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 24 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of this.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				8 2 0 3 5 0 8			
1. FOR STATE REGISTRAR				REG. NO.			
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST IRVIN FREDERICK ARMSTRONG, J.R.				2a. DATE OF DEATH MONTH DAY YEAR Feb 3 1982		2b. HOUR 6:04 PM	
3. SEX Male		4. RACE Caucasian		5. DATE OF BIRTH MONTH DAY YEAR 12 01 1937		6. AGE (IN YEARS LAST BIRTHDAY) YRS. MONTHS DAYS 44	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MD.		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City MD.	
10. CITY OR TOWN OF DEATH BALTIMORE		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) South Baltimore General Hospital		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) A+P Warehouse Worker		12b. KIND OF BUSINESS OR INDUSTRY	
13a. STATE MD		13b. COUNTY ANNE ARUNDEL		13c. CITY OR TOWN Baltimore		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST IRVIN F. ARMSTRONG, Sr		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Helen Smallwood		13e. STREET ADDRESS 114 Bonnie View Rd. Glen Burnie			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 219-32-6759		17. INFORMANT Dr. Santoxano		ADDRESS Baltimore 1022 Charing Martin Ct.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 4100 DUE TO, OR AS A CONSEQUENCE OF (b) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last DUE TO, OR AS A CONSEQUENCE OF (c) Extensive Myocardial Infarction APPROX 36 hrs.							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (1) (this hospital) attended the deceased from 2/2/82 19, to 2/3/82 19, that (1) (we) last saw the deceased alive on 2/3/82 19, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (1) (we) did (did not) view the body after death.							
22b. SIGNATURE Ricardo Santoxano				DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		22c. DATE SIGNED 2/3/82	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) R. Santoxano				22e. ADDRESS 1022 Charing Martin Ct. Apt. G. Baltimore			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 8 Feb 82		23c. NAME OF CEMETERY OR CREMATORY Cedar Hill Cemetery Baltimore		23d. LOCATION CITY OR TOWN COUNTY STATE AA MD	
24. FUNERAL DIRECTOR NAME James S. Kirkley, Glen Burnie, MD				25a. DATE REC'D. BY REGISTRAR FEB 5 1982		25b. REGISTRAR'S SIGNATURE [Signature]	



STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 2 0 3 5 0 9

1- FOR
STATE
REGISTRAR

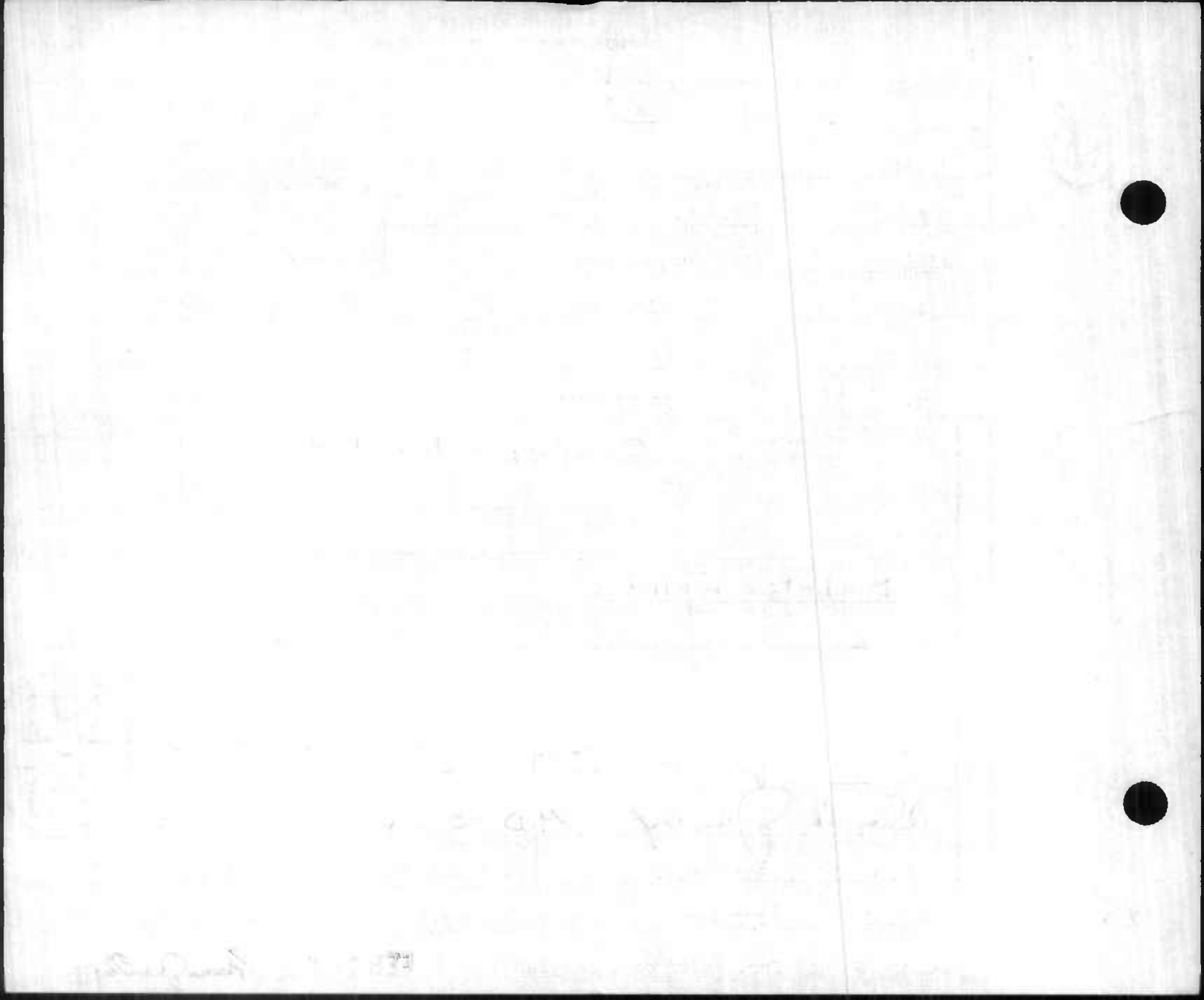
REG. NO.

1. DECEASED NAME (TYPE OR PRINT) Josephine Maria Arthur			2a. DATE OF DEATH MONTH DAY YEAR February 17, 1982		2b. HOUR 5:30 AM
3. SEX Female	4. RACE White	5. DATE OF BIRTH MONTH DAY YEAR December 7, 1921		6. AGE (IN YEARS LAST BIRTHDAY) 60 YRS.	IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) New Jersey	7b. CITIZEN OF WHAT COUNTRY? U.S.A.	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City MD.	
10. CITY OR TOWN OF DEATH Baltimore	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 6203 Burgess Ave		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Housewife		12b. KIND OF BUSINESS OR INDUSTRY
13a. STATE Maryland			13b. COUNTY Baltimore	13c. CITY OR TOWN Baltimore	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
14. FATHER'S NAME FIRST MIDDLE LAST Frank Adams			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Elvira Forte		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. 217-12-0783		17. INFORMANT ADDRESS Mr Frank Arthur Same	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary artery disease 4149 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) Diabetes mellitus					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from May 6, 1959 to Feb 17, 1982 , that (I) (we) last saw the deceased alive on Jan 12, 1982 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did not) see the body after death.					
22b. SIGNATURE R. Donald Jandorf M.D. DEGREE M.D.				22c. DATE SIGNED 2-17-82	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) R. Donald Jandorf M.D.				22e. ADDRESS 7403 Harford Rd Baltimore, Maryland	
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 2/20/82		23c. NAME OF CEMETERY OR CREMATORY Gardens Of Faith	
23d. LOCATION CITY OR TOWN COUNTY STATE Baltimore, Maryland		25a. DATE REC'D. BY REGISTRAR FEB 18 1982			
24. FUNERAL DIRECTOR NAME ADDRESS Leonard J Ruck Inc. Baltimore, Maryland				25b. REGISTRAR'S SIGNATURE Rene J. Smith	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. It may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

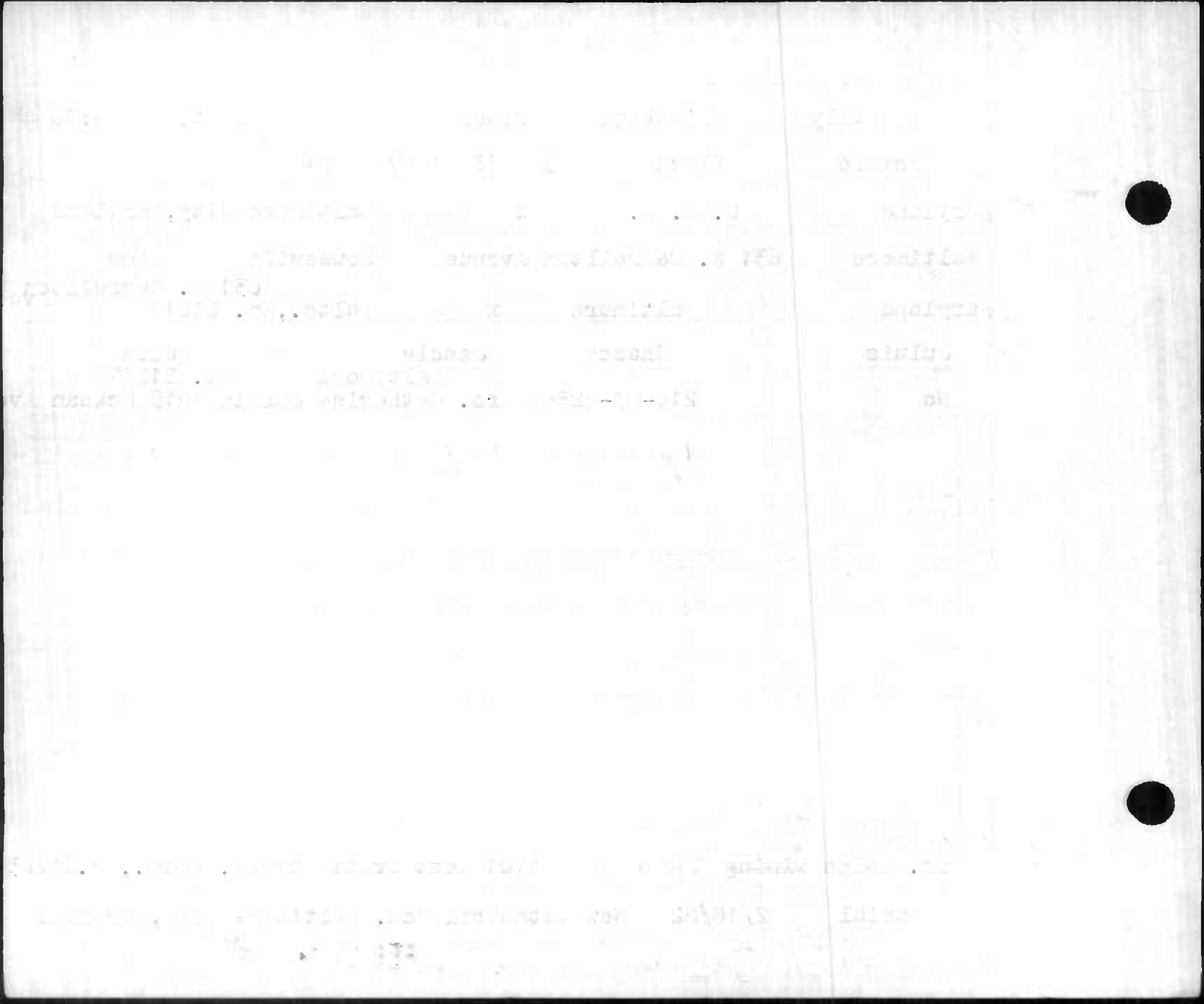
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1- FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 2 0 3 5 1 0

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) Lilly Elizabeth Arthur			2a. DATE OF DEATH MONTH DAY YEAR 2 13 82		2b. HOUR 5:10 AM
3. SEX Female	4. RACE Black	5. DATE OF BIRTH MONTH DAY YEAR 3 13 1897	6. AGE (IN YEARS (LAST BIRTHDAY)) 84	7. IF UNDER 1 YEAR MONTHS DAYS HOURS MIN. YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland	7b. CITIZEN OF WHAT COUNTRY? U. S. A.	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City, Maryland MD.		
10. CITY OR TOWN OF DEATH Baltimore	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 631 N. Carrollton Avenue		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Housewife	12b. KIND OF BUSINESS OR INDUSTRY Home	
13a. STATE Maryland	13b. COUNTY	13c. CITY OR TOWN Baltimore	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET ADDRESS 631 N. Carrollton Ave Balto., Md. 21217	
14. FATHER'S NAME FIRST MIDDLE LAST Juluis Chase		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Jessie Queen			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. 216-03-8288	17. INFORMANT Baltimore Md. 21217 Mrs. Catherine Jasmin 1015 McKean Ave		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Hypertension and arteriosclerotic cardio-vascular disease</u> 4029 DUE TO, OR AS A CONSEQUENCE OF (b) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) _____ DUE TO, OR AS A CONSEQUENCE OF APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 1 year					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1B, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) last saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE Ralph Twining MD				22c. DATE SIGNED	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Dr. Ralph Twining TWINING				22e. ADDRESS 1701 West Pratt Street, Balto., Md. 21223	
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 2/18/82	23c. NAME OF CEMETERY OR CREMATORY New Cathedral Cem.		23d. LOCATION CITY OR TOWN COUNTY STATE Baltimore City, Maryland
24. FUNERAL DIRECTOR NAME BALTIMORE		ADDRESS MARYLAND 21216		25. DATE REC'D BY REGISTRAR FEB 17 1982	
HERBERT E. NUTTER FUNERAL HOME 3035 W. NORTH AVE					



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 10 days after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				8-2 03511			
1. FOR STATE REGISTRAR				REG. NO.			
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST HANNA S. ARUSELL				2a. DATE OF DEATH MONTH DAY YEAR February 2, 1982		2b. HOUR 12 noon M.	
3 SEX Female		4 RACE White		5. DATE OF BIRTH MONTH DAY YEAR March 8, 1891		6. AGE (IN YEARS LAST BIRTHDAY) 90 YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Sweden		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City MD.	
10. CITY OR TOWN OF DEATH Baltimore		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Long Green Nursing Center		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Homemaker		12b. KIND OF BUSINESS OR INDUSTRY Own Home	
13a. STATE Maryland		13b. COUNTY Baltimore		13c. CITY OR TOWN Baltimore		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST Carl Scher		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Ingrid Londgren		13e. STREET ADDRESS 4401 Roland Avenue			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. 569 12 4092		17. INFORMANT ADDRESS Sonia A. Hendricks, Balto., Md.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Ischemia</u> <u>3419</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>Cerebral Sclerosis</u> DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.						APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>unknown</u> <u>unknown</u>	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) _____							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from <u>MAY 19, 1976</u> , to <u>2/2, 1982</u> , that (I) (we) lost saw the deceased alive on <u>JAN 31st 82</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did not) view the body after death.							
22b. SIGNATURE <u>Martin Singewald</u>				DEGREE <u>MD</u>		22c. DATE SIGNED <u>2/3/82</u>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Dr. Martin Singewald, M.D.				22e. ADDRESS 11 E. Chase St., Balto., Md.			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Cremation		23b. DATE 2/3/82		23c. NAME OF CEMETERY OR CREMATORY Green Mount		23d. LOCATION CITY OR TOWN COUNTY STATE Balto., Md.	
24. FUNERAL DIRECTOR NAME ADDRESS Henry W. Jenkins & Sons Co. 4905 York Road Balto., Md. 21212				25a. DATE REC'D. BY REGISTRAR FEB 5 1982		25b. REGISTRAR'S SIGNATURE <u>James J. North</u>	

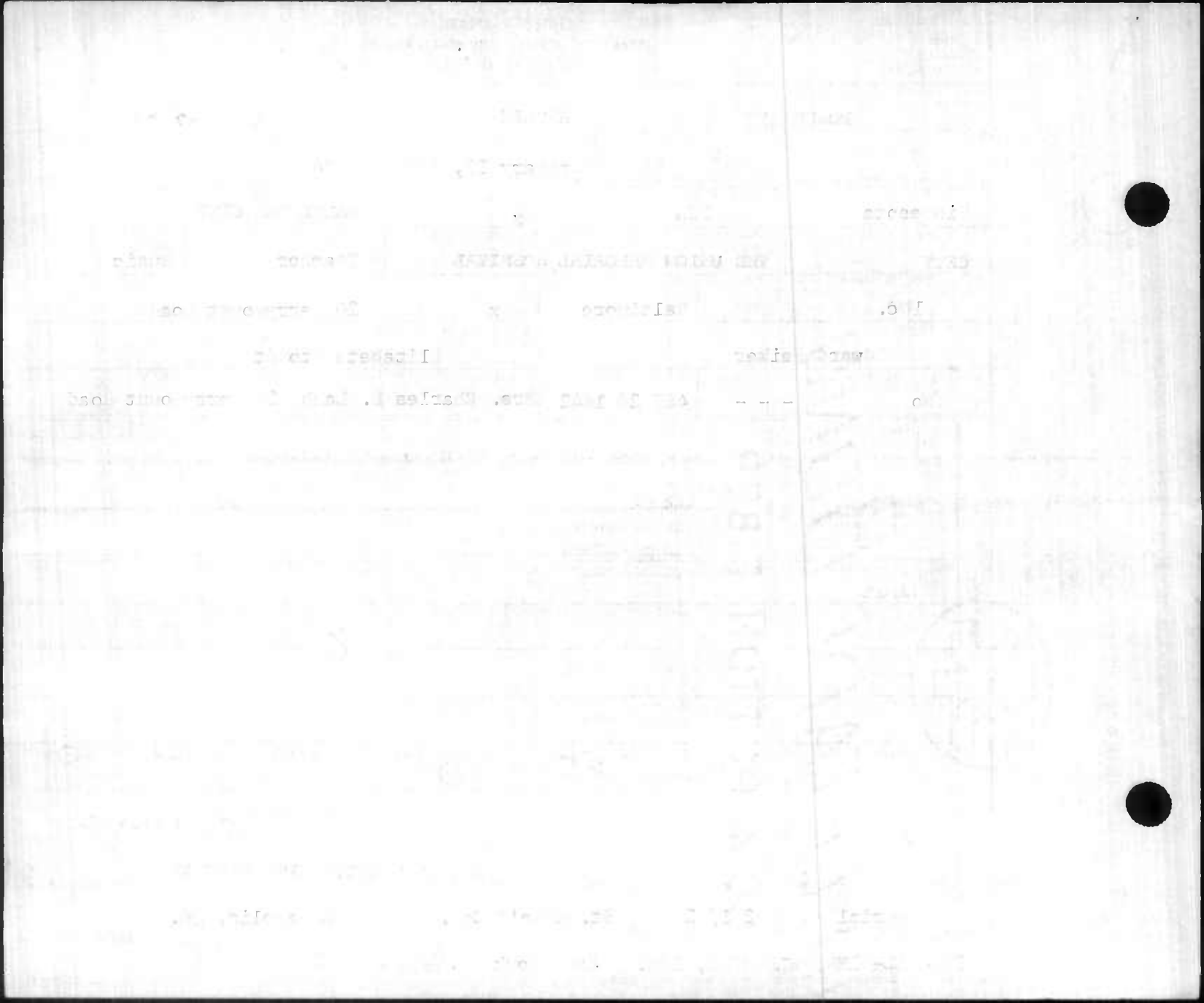
U. S. Department of the Interior
Bureau of Land Management
Washington, D. C. 20240
Dear Sir:
Enclosed for you are two copies of a report
entitled "Report of the Survey of the
Public Lands in the State of California
for the Year 1900". The report contains
a detailed description of the public lands
in California, and a list of the lands
which have been surveyed and patented
since the year 1850. The report is
published in two volumes, and is
available for sale at the following
prices: One volume, \$1.00; Two
volumes, \$2.00. The report is
also available for sale in the form of
a single copy, at the price of \$1.00.
Very respectfully,
Director

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a single copy, at the price of \$1.00.
Very respectfully,
Director

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon copies. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner should be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										8 2 0 3 5 1 2	
1. FOR STATE REGISTRAR		REG. NO.									
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST ROSEMARIE ASPLIN						2a. DATE OF DEATH MONTH DAY YEAR 02 25 82		2b. HOUR M 11			
3. SEX F		4. RACE W		5. DATE OF BIRTH MONTH DAY YEAR January 30, '88		6. AGE (IN YEARS LAST BIRTHDAY) 94 YRS.		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN. 0 0 0 0			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Minnesota		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE CITY MD.					
10. CITY OR TOWN OF DEATH CITY		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) THE UNION MEMORIAL HOSPITAL				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Teacher		12b. KIND OF BUSINESS OR INDUSTRY Music			
13a. STATE Md.		13b. COUNTY		13c. CITY OR TOWN Baltimore		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 20 Merrymount Road			
14. FATHER'S NAME FIRST MIDDLE LAST Edward Feiker				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Elizabeth Stoudt							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 469 28 1642		17. INFORMANT ADDRESS Mrs. Charles E. Lamb 20 Merrymount Road							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Probable shock & cardiovascular collapse DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last: (b) Sepsis DUE TO, OR AS A CONSEQUENCE OF (c) pneumonia										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) NONE											
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR 2/05 1982		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>				21e. PLACE OF INJURY (AT HOME STREET, FACTORY OFFICE FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from 2/05 1982 to 2/25 1982 , that (I) (we) last saw the deceased alive on 2/05 1982 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE Laurie J Matthews MD						DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 2/25/82			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Laurie J Matthews MD						22e. ADDRESS 201 EAST UNIVERSITY PARKWAY					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 3/1/82		23c. NAME OF CEMETERY OR CREMATORY St. Anne's Cem.		23d. LOCATION CITY OR TOWN COUNTY STATE Annapolis, Md.					
24. FUNERAL DIRECTOR NAME ADDRESS MITCHELL-WIEDEFELD HOME, INC. 6500 York Rd.						25a. DATE REC'D. BY REGISTRAR MAR 1 1982					

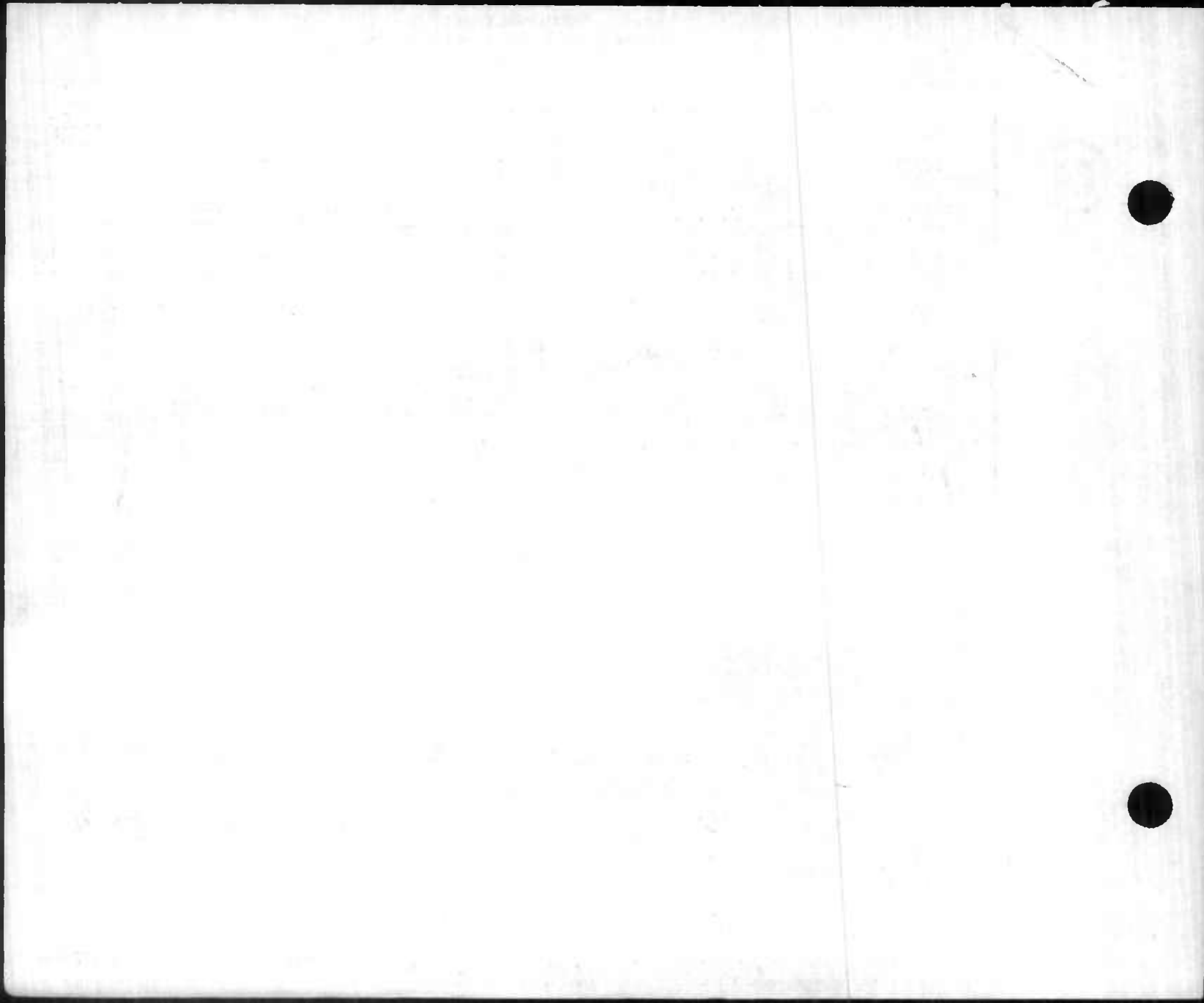


TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 4 may be retained by the hospital or attending physician.

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IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of this.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										8 2 0 3 5 1 3	
1 - FOR STATE REGISTRAR		REG. NO.									
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST ARTHUR WILLIAM ATKINSON JR.						2a. DATE OF DEATH MONTH DAY YEAR 2 27 82		2b. HOUR 2:40p M			
3. SEX MALE		4. RACE BLACK		5. DATE OF BIRTH MONTH DAY YEAR 2 15 23		6. AGE (IN YEARS LAST BIRTHDAY) 59 YRS.		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MARYLAND		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE CITY MD					
10. CITY OR TOWN OF DEATH BALTIMORE		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) VAMC 3900 LOCH RAVEN BLVD 21218				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY			
13a. STATE MARYLAND		13b. COUNTY		13c. CITY OR TOWN BALTIMORE		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 3009 OAKFORD AVENUE 21215			
14. FATHER'S NAME FIRST MIDDLE LAST ARTHUR AT ATKINSON		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST EMMA ATKINSON HAWKINS		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) YES WWII							
16b. SOCIAL SECURITY NO. 216125253		17. INFORMANT ADDRESS Lucy Sherrod 3009 Oakford Ave. VAMC 3900 LOCH RAVEN BLVD 21218									
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Cardiac Arrest 4100 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) Myocardial Infarction DUE TO, OR AS A CONSEQUENCE OF (c) Coronary Artery Disease									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH minutes Days Years		
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: 0											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE							
22a. I certify that (I) (this hospital) attended the deceased from FEBRUARY 27 , 19 82 , to FEBRUARY 27 , 19 82 , that <input checked="" type="checkbox"/> (I) (we) last saw the deceased alive on FEBRUARY 27 , 19 82 , and that in <input checked="" type="checkbox"/> (my) (our) opinion death occurred on the date and hour and from the causes stated above. <input checked="" type="checkbox"/> (I) (we) did not see the body after death.											
22b. SIGNATURE A. J. Lomant MD				DEGREE				22c. DATE SIGNED 2/28/82			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) A. J. Lomant MD				22e. ADDRESS 3900 LOCH RAVEN BLVD 21218							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 3/3/82		23c. NAME OF CEMETERY OR CREMATORY Md. Veteran Cem.		23d. LOCATION CITY OR TOWN COUNTY STATE Crownsville MD					
24. FUNERAL DIRECTOR NAME Wm. C. March F/H				ADDRESS 1101 E. North Ave.		25a. DATE REC'D. BY REGISTRAR MAR 1 1982					
						25b. REGISTRAR'S SIGNATURE Thomas Van Natten					



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified by page 3.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										REG. NO.	
1 - STATE REGISTRAR										8 2 0 3 5 1 4	
1 DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST MARY C. BACIGALUPA						2a DATE OF DEATH MONTH DAY YEAR 2 -18-82		2b HOUR 9:30 AM			
3 SEX Female		4 RACE White		5 DATE OF BIRTH MONTH DAY YEAR Aug 19, 1895		6 AGE (IN YEARS LAST BIRTHDAY) 87 yrs		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN.			
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b CITIZEN OF WHAT COUNTRY? U.S.A		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE CITY MD.					
10 CITY OR TOWN OF DEATH BALTIMORE		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) UNION MEMORIAL HOSPITAL				12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Retired		12b KIND OF BUSINESS OR INDUSTRY - -			
13a STATE Maryland		13b COUNTY - -		13c CITY OR TOWN Baltimore		13d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e STREET ADDRESS 114 W. University Pkwy			
14 FATHER'S NAME FIRST MIDDLE LAST William Wilson				15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST unknown							
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) - -		17 INFORMANT ADDRESS Robert Bacigalupa-4412 Buchanan Ave 21211							
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CRAB AND VASCULAR DEMENTIA 4140 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last: (b) CORONARY ARTERIO SCLEROTIC HEART DISEASE DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) _____											
19a DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)							
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE							
22a. I certify that (I) (this hospital) attended the deceased from _____, 19____ to _____, 19____. that (I) (we) last saw the deceased alive on _____, 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did not) view the body after death.											
22b. SIGNATURE Walter R. Burkles, MD				DEGREE MD				22c. DATE SIGNED 2-19-82			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) WALTER BURKLES, MD				22e. ADDRESS UNION MEMORIAL HOSPITAL							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 2/20/82		23c. NAME OF CEMETERY OR CREMATORY New Cathedral Cem.		23d. LOCATION CITY OR TOWN COUNTY STATE Baltimore, Maryland					
24 FUNERAL DIRECTOR NAME A. Alan Seitz Funeral Home				ADDRESS 3818 Roland Ave.		25a. DATE REC'D. BY REGISTRAR FEB 23 1982		25b. REGISTRAR'S SIGNATURE James J. Nathan			

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 2 0 3 5 1 5

1. FOR STATE REGISTRAR		REG. NO.	
1. DECEASED NAME (TYPE OR PRINT)		2a. DATE OF DEATH	
FIRST MIDDLE LAST FRANCES A. BACON		MONTH DAY YEAR 2/15/82	
3. SEX		4. RACE	
Female		White	
5. DATE OF BIRTH		6. AGE (IN YEARS LAST BIRTHDAY)	
MONTH DAY YEAR Mar. 11, 1903		78 YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?	
Michigan		USA	
8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH	
BALTIMORE		BALTIMORE CITY MD.	
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)	
BALTIMORE		UNION MEMORIAL HOSPITAL	
12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY	
Homemaker		Own Home	
13a. STATE		13b. COUNTY	
Maryland		Baltimore	
13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?	
Baltimore		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
13e. STREET ADDRESS		14. FATHER'S NAME	
5506 Kemper Road		FIRST MIDDLE LAST John Atchinson	
15. MOTHER'S MAIDEN NAME		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)	
Bertha Fillingham		No	
16b. SOCIAL SECURITY NO.		17. INFORMANT	
216 32 9284		Dr. Hilary E. Bacon	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiorespiratory Arrest</u> 4292 DUE TO, OR AS A CONSEQUENCE OF (b) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) _____		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 1 hour	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) CHF ASCVD			
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	
20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?	
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19	
21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)		21d. INJURY OCCURRED	
21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (1) (this hospital) attended the deceased from 2/12, 19 82, to 2/15, 19 82, that (1) (we) saw the deceased alive on 2/15, 19 82, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (1) (we) (did not) view the body after death.		22b. SIGNATURE David M. Fishbein M.D.	
22c. DATE SIGNED 2/15/82		22d. PHYSICIAN'S NAME (TYPE OR PRINT) David M. Fishbein M.D.	
22e. ADDRESS UNION MEMORIAL HOSPITAL		22f. DATE REC'D. BY REGISTRAR 18 1982	
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Cremation		23b. DATE 2/17/82	
23c. NAME OF CEMETERY OR CREMATORY Green Mount		23d. LOCATION CITY OR TOWN COUNTY STATE Balto. Md.	
24. FUNERAL DIRECTOR NAME Henry W. Jenkins & Sons Co. ADDRESS 4905 York Road Balto., Md. 21212		25. REGISTRAR'S SIGNATURE James J. Nathan	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the registrar, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner may be notified.

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be filled within 72 hours after death. The certificate must be returned by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 2 0 3 5 1 6

1. FOR
STATE
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) ELDER CURTIS BACOTE SR.			2a. DATE OF DEATH MONTH DAY YEAR Feb. 20 1982		2b. HOUR 9:28 P.M.
3. SEX Male	4. RACE Black	5. DATE OF BIRTH MONTH DAY YEAR 11 25 12		6. AGE (IN YEARS LAST BIRTHDAY) 69 YRS.	IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) S.C.	7b. CITIZEN OF WHAT COUNTRY? USA	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE CITY MD.	
10. CITY OR TOWN OF DEATH BALTIMORE	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) UNION MEMORIAL HOSPITAL		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY
13a. STATE MD			13b. COUNTY	13c. CITY OR TOWN Baltimore	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
14. FATHER'S NAME FIRST MIDDLE LAST Willie Bacote			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Hattie		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) Yes		16b. SOCIAL SECURITY NO. 250-18-5474		17. INFORMANT ADDRESS Frances V. Bacote 1018 W. 42nd. St.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>RESPIRATORY ARREST</u> <u>4360</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>Left CVA.</u> DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a). <u>Pneumonia R. CVA.</u>					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)	
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from <u>Feb 20</u> , 19 <u>82</u> , to <u>Feb 20</u> , 19 <u>82</u> , that (I) (we) lost saw the deceased alive on <u>Feb 20</u> , 19 <u>82</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE <u>Charles W. Hicks, III</u>		DEGREE M.D.		22c. DATE SIGNED 2-20-82	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <u>Charles W. Hicks, III</u>		22e. ADDRESS <u>c/o Union Memorial Hosp. Balto Md</u>			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 2/27/82	23c. NAME OF CEMETERY OR CREMATORY Lakeview Mem. pk.		23d. LOCATION CITY OR TOWN COUNTY STATE Sykesville MD
24. FUNERAL DIRECTOR NAME Wm. C. March F/H		ADDRESS 1101 E. North Ave.		25a. DATE REC'D. BY REGISTRAR FEB 22 1982	
				25b. REGISTRAR'S SIGNATURE <u>James J. Martin</u>	

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STATE OF MARYLAND

DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 2 0 3 5 1 7

1 - FOR
STATE
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST JOHN T. BAGBY			2a. DATE OF DEATH MONTH DAY YEAR FEBRUARY 15, 1982		2b. HOUR 09:38AM
3. SEX male	4. RACE black	5. DATE OF BIRTH MONTH DAY YEAR 6 30 1916		6. AGE (IN YEARS LAST BIRTHDAY) 65 YRS.	IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Va	7b. CITIZEN OF WHAT COUNTRY? USA	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE CITY MD.	
10. CITY OR TOWN OF DEATH Baltimore	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) THE JOHNS HOPKINS HOSPITAL		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY
13a. STATE Md	13b. COUNTY Baltimore	13c. CITY OR TOWN Baltimore	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET ADDRESS 715 N. Glover Street	
14. FATHER'S NAME FIRST MIDDLE LAST Jeramiah Bagby		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Mary C. Williams			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) Yes		16b. SOCIAL SECURITY NO. 225-14-7416		17. INFORMANT ADDRESS Mamie Bagby 715 N. Glover Street	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Septic shock 3030 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 24 hours					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a) Alcohol Abuse, Renal failure, Gastrointestinal bleed					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from Feb 14 , 19 82 , to Feb 15 , 19 82 that (I) (we) lost saw the deceased alive on Feb 15 , 19 82 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE S.B. Bolger MD		DEGREE		22c. DATE SIGNED Feb 15/82	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Bolger, Graeme		22e. ADDRESS Johns Hopkins, Baltimore 21205			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 2/19/82		23c. NAME OF CEMETERY OR CREMATORY Md Veteran Cemetery	
23d. LOCATION CITY OR TOWN COUNTY STATE Crownsville Md		24. FUNERAL DIRECTOR William C. March F/H 1101 E. North Avenue			
25a. DATE RECEIVED BY REGISTRAR FEB 17 1982		25b. REGISTRAR'S SIGNATURE Thomas J. [Signature]			

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner should be notified at once.

BP

DHMH - 16 50M 7/77
(VRA 15 (4))

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 2 0 3 5 1 8

FOR
1 - STATE
REGISTRAR

REG. NO.

1 DECEASED NAME (TYPE OR PRINT) LILLIAN P. May BAILEY			2a DATE OF DEATH MONTH DAY YEAR 2 22 82			2b HOUR 12 ³⁰ A					
3 SEX Female		4 RACE White		5 DATE OF BIRTH MONTH DAY YEAR 5 17 96		6 AGE (IN YEARS LAST BIRTHDAY) 85 YRS.		7b HOUR MONTHS DAYS HOURS MIN.			
7a BIRTH-PLACE (STATE OR FOREIGN COUNTRY) Frederick Co. Md.		7b CITIZEN OF WHAT COUNTRY? U.S.A.		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH Baltimore City MD.					
10 CITY OR TOWN OF DEATH Baltimore		11 NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Baltimore City Hospitals				12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Retired		12b KIND OF BUSINESS OR INDUSTRY Lambert Co.			
13a STATE Maryland			13b COUNTY Anne Arund.		13c CITY OR TOWN Severn		13d INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e STREET ADDRESS 1921 Huguenot Place 21144		
14 FATHER'S NAME FIRST MIDDLE LAST James W. Boston			15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Sarah Fogle			16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No				16b SOCIAL SECURITY NO. 217-01-2385	
17 INFORMANT ADDRESS William F. Bailey 3900 Glenhurst Rd. #22											
18 CAUSE OF DEATH: Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: 5788 IMMEDIATE CAUSE (a) Hepato-Pancreatic Syndrome DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost: (b) Liver Disease upon Etymology DUE TO, OR AS A CONSEQUENCE OF (c)									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)											
19a DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from 2 21 19 82, to 2 22 19 82, that (I) (we) lost saw the deceased alive on 2-22 19 82, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) did (did not) view the body after death.											
22b. SIGNATURE J. R. Schachner					DEGREE MD			22c. DATE SIGNED 2/24/82			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Jay Schachner					22e. ADDRESS 116 W Univ. Pkwy 21211						
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE 2-25-82		23c. NAME OF CEMETERY OR CREMATORY Meadowridge Mem. Pk.			23d. LOCATION CITY OR TOWN COUNTY STATE Elkridge Howard Co. Md.			
24. FUNERAL DIRECTOR NAME C.S. Zeiler & Son Inc.					ADDRESS 6224 Eastern Avenue			25a. DECEASED'S REGISTRATION NO. FEB 25 1982			
					25b. REGISTRAR'S SIGNATURE James J. [Signature]						

MEDICAL CERTIFICATION

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 must be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 1 and 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked on item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

DHMH - 16 50M 1/81
(VRA 15, 4)

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH									
1. FOR STATE REGISTRAR		2a. DATE OF DEATH				REG. NO.			
1. DECEASED NAME (TYPE OR PRINT)		2b. DATE OF DEATH				REG. NO.			
Foster Nicholas Baker		2/14/1982				1482			
3 SEX		4 RACE		5 DATE OF BIRTH		6 AGE (IN YEARS LAST BIRTHDAY)		7b. CITIZEN OF WHAT COUNTRY?	
Male		White		11/3/98		83		USA	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH		10 CITY OR TOWN OF DEATH	
Delaware		USA				Baltimore City		Baltimore	
11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK OR BUSINESS DURING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY		13a. STREET ADDRESS		13b. CITY OR TOWN	
St. Agnes Hospital		Retired Tool Salesman		L.A. Benson		609 Winans Way		21229	
14. FATHER'S NAME		15. MOTHER'S MAIDEN NAME		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO.		17 INFORMANT	
Edgar Baker		Emma Irene Foster		No		215-10-6875		A, Clara M. Baker Same as # 13	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1: DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiopulmonary arrest</u> 1539									
DUE TO, OR AS A CONSEQUENCE OF (b) <u>Colon cancer 1/2 total colectomy</u>									
DUE TO, OR AS A CONSEQUENCE OF (c) <u></u>									
PART 2: OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <u></u>									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?			
12/28/81				YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
		HOUR A.M. MONTH DAY YEAR							
		P.M. 19							
21d. INJURY OCCURRED		21e. PLACE OF INJURY		21f. LOCATION		21g. CITY OR TOWN			
WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		[AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.]		STREET		CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from <u>12/19</u> 19 <u>81</u> , to <u>2/14</u> 19 <u>82</u> , that (I) (we) lost									
saw the deceased alive on <u>2/14</u> 19 <u>82</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated									
22b. SIGNATURE		DEGREE		ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		22c. DATE SIGNED			
<u>LIN, POW-SEI</u>						<u>2/14/82</u>			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION			
Burial		2/17/82		Druid Ridge		Pikesville Md.			
24 FUNERAL DIRECTOR		25a. DATE REG'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE		25c. CITY OR TOWN			
Witzke P.A.		FEB 16 1982		<u>James J. Nathan</u>		25d. COUNTY STATE			
1630 Edmondson Avenue, Catonsville, Md.		21228							

[Faint, illegible text visible through the paper from the reverse side]

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.FOR
1- STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 2 0 3 5 2 0

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) George M. Baker, Sr.			2a. DATE OF DEATH MONTH DAY YEAR February 18, 1982			2b. HOUR 2:20a M					
3. SEX Male		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR 3-21-08		6. AGE (IN YEARS LAST BIRTHDAY) 73 YRS		7. IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN.			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Md.		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City MD.					
10. CITY OR TOWN OF DEATH Baltimore		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Maryland General Hospital				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Book keeper Ret.		12b. KIND OF BUSINESS OR INDUSTRY			
13a. STATE Md.			13b. COUNTY Balto		13c. CITY OR TOWN Balto		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 5617 Greenhill Ave.		
14. FATHER'S NAME FIRST MIDDLE LAST John Baker			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Molly Thim			16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) No				16b. SOCIAL SECURITY NO. 213--05-4417	
17. INFORMANT Margaret M. Baker, 5617 Greenhill Ave.			18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Respiratory Failure</u> 4340 DUE TO, OR AS A CONSEQUENCE OF (b) <u>Cerebral Thrombosis With Right Hemiparesis</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH								
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <u>Arteriosclerotic Cardiovascular Disease, Carcinoma of Larynx</u>											
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)						
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE						
22a. I certify that (I) (this hospital) attended the deceased from <u>February 1</u> , 19 <u>82</u> , to <u>February 18</u> , 19 <u>82</u> , that (I) (we) last saw the deceased alive on <u>February 18</u> , 19 <u>82</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above (I) (we) (did) <u>not</u> view the body after death.											
22b. SIGNATURE <u>Huang-Ta Lin, M.D.</u>			DEGREE MD.			ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>			22c. DATE SIGNED		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Huang-Ta Lin, M.D.			22e. ADDRESS C/O Maryland General Hospital								
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE 2-22-82		23c. NAME OF CEMETERY OR CREMATORY Dulaney Valley		23d. LOCATION CITY OR TOWN COUNTY STATE Balto. Balto. Md.				
24. FUNERAL DIRECTOR NAME Leonard J. Ruck, Inc., 5305 Harford Rd.						25a. DATE REC'D. BY REGISTRAR FEB 19 1982		25b. REGISTRAR'S SIGNATURE <u>Thomas J. North</u>			

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1. FOR
STATE
REGISTRAR

KENNETH

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

8 2 0 3 5 2 1

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST KENNETH H. BAKER			2r. DATE OF DEATH MONTH DAY YEAR 2-5-82		2b. HOUR 4 ⁰⁰ PM		
3. SEX MALE		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR 10 2 25		6. AGE (IN YEARS LAST BIRTHDAY) YRS. MONTHS DAYS HOURS MIN 56	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City MD.	
10. CITY OR TOWN OF DEATH Balt		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Balt. City Hosp		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Clerk		12b. KIND OF BUSINESS OR INDUSTRY Beth. Steel	
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) STATE Maryland		13b. CITY OR TOWN Baltimore		13c. STREET ADDRESS 2605 Brannan Avenue			
14. FATHER'S NAME FIRST MIDDLE LAST Jesse Baker		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Mabel Eubank		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) Yes		16b. SOCIAL SECURITY NO. 225-20-7593	
17. INFORMANT Pat R. Baker		ADDRESS 2605 Brannan Ave. Balto., MD. 21219					

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY

4149

IMMEDIATE CAUSE (a)

DUE TO, OR AS A CONSEQUENCE OF

(b) Bact. Group A. disease

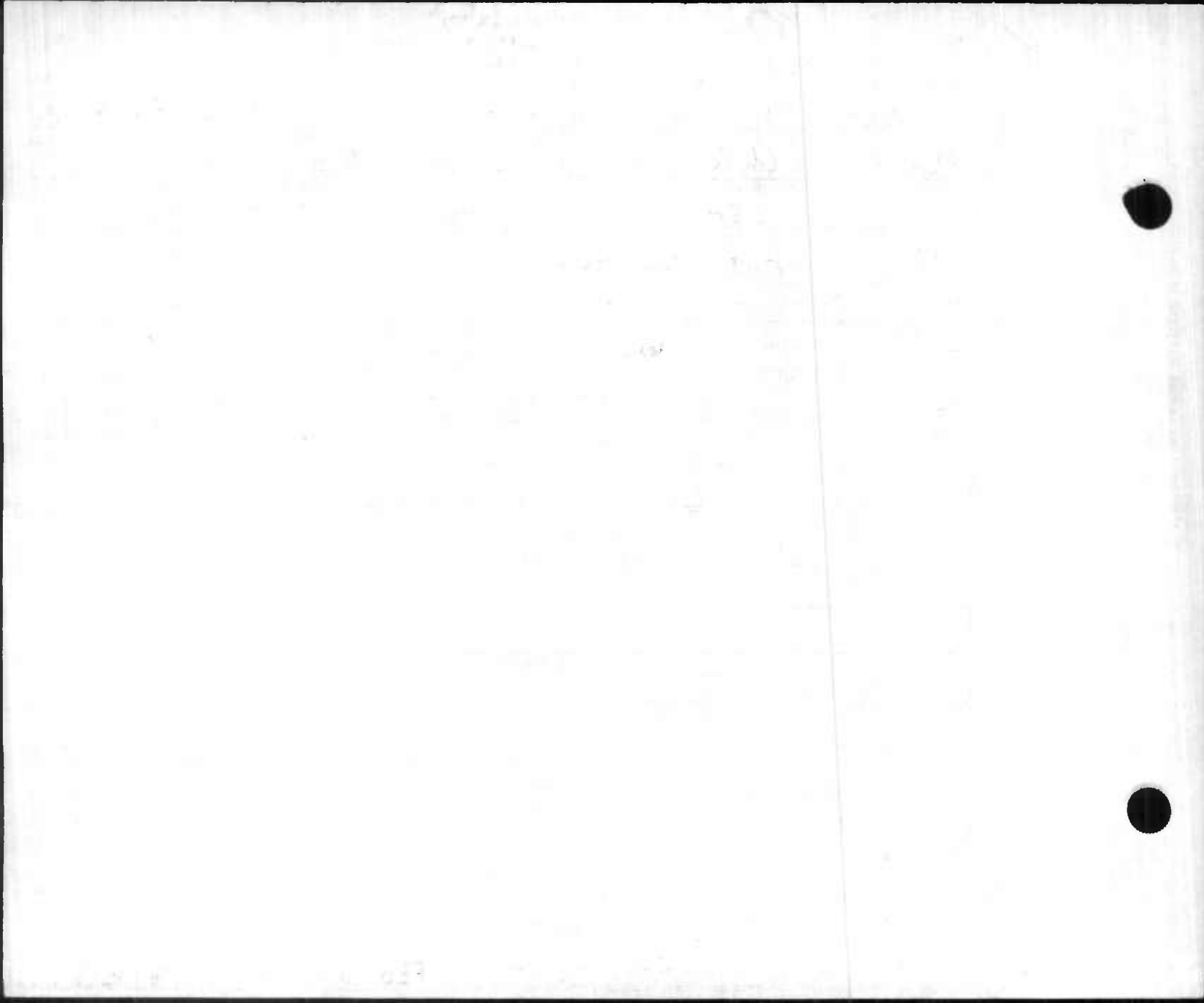
DUE TO, OR AS A CONSEQUENCE OF

(c)

PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)

19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from 2/2/82, 19 82, to 2/5, 19 82, that (I) (we) last saw the deceased alive on 19, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE A. JAIN				DEGREE		22c. DATE SIGNED 2/5/82	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) A. JAIN				22e. ADDRESS BALT. CITY HOSP.			

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 2/9/1982		23c. NAME OF CEMETERY OR CREMATORY Oak Lawn		23d. LOCATION CITY OR TOWN COUNTY STATE Baltimore Maryland	
24. FUNERAL DIRECTOR NAME Duda-Ruck, Inc. 7922 Wise Avenue Dundalk, MD. 21222				25a. DATE REC'D. BY REGISTRAR FEB 9 1982		25b. REGISTRAR'S SIGNATURE [Signature]	



REG. NO.

DHMH - 17
(VR A15 ME (5))
15M 2/80

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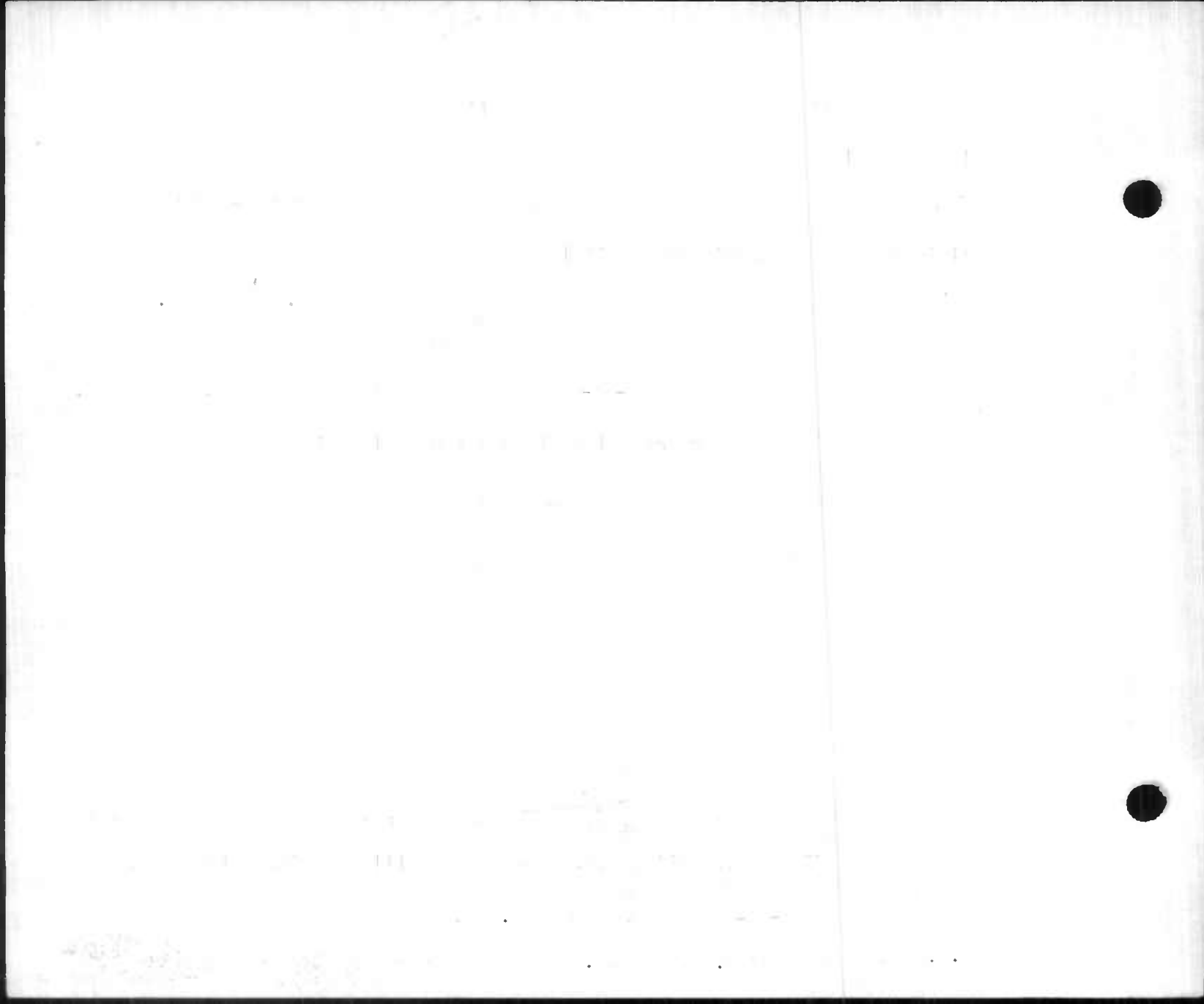


SEP 14 1964

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, THE EXAMINER SHOULD EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 1b. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH. WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH										REG. NO. 5 2 0 3 5 2 3	
1- FOR STATE REGISTRAR											
1. DECEASED NAME (TYPE OR PRINT)						2a. DATE KNOWN OF DEATH		2b. HOUR			
Otis						2c. DATE ESTIMATED		2d. HOUR			
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (IN YEARS)		7. IF UNDER 1 YR.		8. IF UNDER 24 HRS.	
Male		Black		9 7 19		62 YRS.		MONTHS		DAYS	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED		NEVER MARRIED		9. BALTIMORE CITY OR COUNTY OF DEATH			
VIRGINIA		US		WIDOWED		DIVORCED		Baltimore City,		MD.	
10. CITY OR TOWN OF DEATH				11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY	
Baltimore				Provident Hospital							
USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)											
13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?		13e. STREET ADDRESS			
MARYLAND				BALTIMORE		YES		1902 W. NORTH AVE.			
14. FATHER'S NAME						15. MOTHER'S MAIDEN NAME					
ROBERT						LOTTIE					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES?						16b. SOCIAL SECURITY NO.		17. INFORMANT		ADDRESS	
(YES, NO, OR UNKNOWN)						230-12-4614		MARGARET WALLS		1902 W. NORTH AVE.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART I DEATH WAS CAUSED BY:											
IMMEDIATE CAUSE (a) Arteriosclerotic cardiovascular disease											
DUE TO, OR AS A CONSEQUENCE OF											
(b)											
DUE TO, OR AS A CONSEQUENCE OF											
(c)											
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a).											
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?						20. AUTOPSY?	
										YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. EXTERNAL CAUSE WAS				21b. TIME OF INJURY				21c. HOW INJURY OCCURRED			
UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				P.M. 19				(ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)			
21d. INJURY OCCURRED				21e. PLACE OF INJURY				21f. LOCATION			
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>				STREET, FACTORY, FARM, ETC.)				STREET CITY OR TOWN COUNTY STATE			
AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>											
22a. I certify that I took charge of the remains described above, held on death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> .											
Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion											
22b. TITLE (SPECIFY)											
M.D. Deputy Chief MEDICAL EXAMINER											
DATE SIGNED 2/9/82											
EXAMINER'S NAME (TYPE OR PRINT) Thomas D. Smith, M.D. ADDRESS III Penn St. Balto., MD.											
23a. BURIAL, CREMATION, REMOVAL				23b. DATE		23c. NAME OF CEMETERY OR CREMATORY				23d. LOCATION	
BURIAL				2-13-82		ARBUTUS MEM. PK.				BALTIMORE MARYLAND	
24. FUNERAL DIRECTOR											
E.L. PHILLIPS 1721 N. MONROE ST. ADDRESS											
25a. DATE REC'D. BY REGISTRAR											
FEB 16 1982											
25b. REGISTRAR'S SIGNATURE											
Frances Santhron											



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 2 0 3 5 2 4

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST IDA BANACHOWSKI			2a. DATE OF DEATH MONTH DAY YEAR 2 21 82			2b. HOUR 1:5A M				
3 SEX FEMALE		4 RACE White		5. DATE OF BIRTH MONTH DAY YEAR 4 20 08		6. AGE (IN YEARS LAST BIRTHDAY) YRS. 73		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Balto., City MD.				
10. CITY OR TOWN OF DEATH Balto. Md.		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Montebello Center				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Waitress		12b. KIND OF BUSINESS OR INDUSTRY		
13a. STATE Maryland			13b. COUNTY		13c. CITY OR TOWN Baltimore		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 1441 Broening Highway	
14. FATHER'S NAME FIRST MIDDLE LAST James O. Harrison			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Julia V. Shipley			16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No				
16b. SOCIAL SECURITY NO. 217-14-3963			17. INFORMANT 1332 Broening Highway Victor A. Belsinger Balto., MD. 21224							
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 4275 CARDIAC ARREST DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____										
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a): COPD										
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)				
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE				
22a. I certify that (I) (this hospital) attended the deceased from 2/21/82 to 5/26 19 81 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.										
22b. SIGNATURE Portuondo Jose			DEGREE MD			ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		22c. DATE SIGNED 2/21 82		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) PORTUONDO JOSE MD			22e. ADDRESS 2201 ARGONNE DR.							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE 2/24/1982		23c. NAME OF CEMETERY OR CREMATORY Sacred Ht of Jesus		23d. LOCATION CITY OR TOWN COUNTY STATE Baltimore Maryland			
24. FUNERAL DIRECTOR NAME Duda-Ruck, Inc			ADDRESS 7922 Wise Avenue Dundalk, MD. 21222			25a. DATE REC'D. BY REGISTRAR FEB 24 1982		25b. REGISTRAR'S SIGNATURE James J. Nathan		



(100)



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

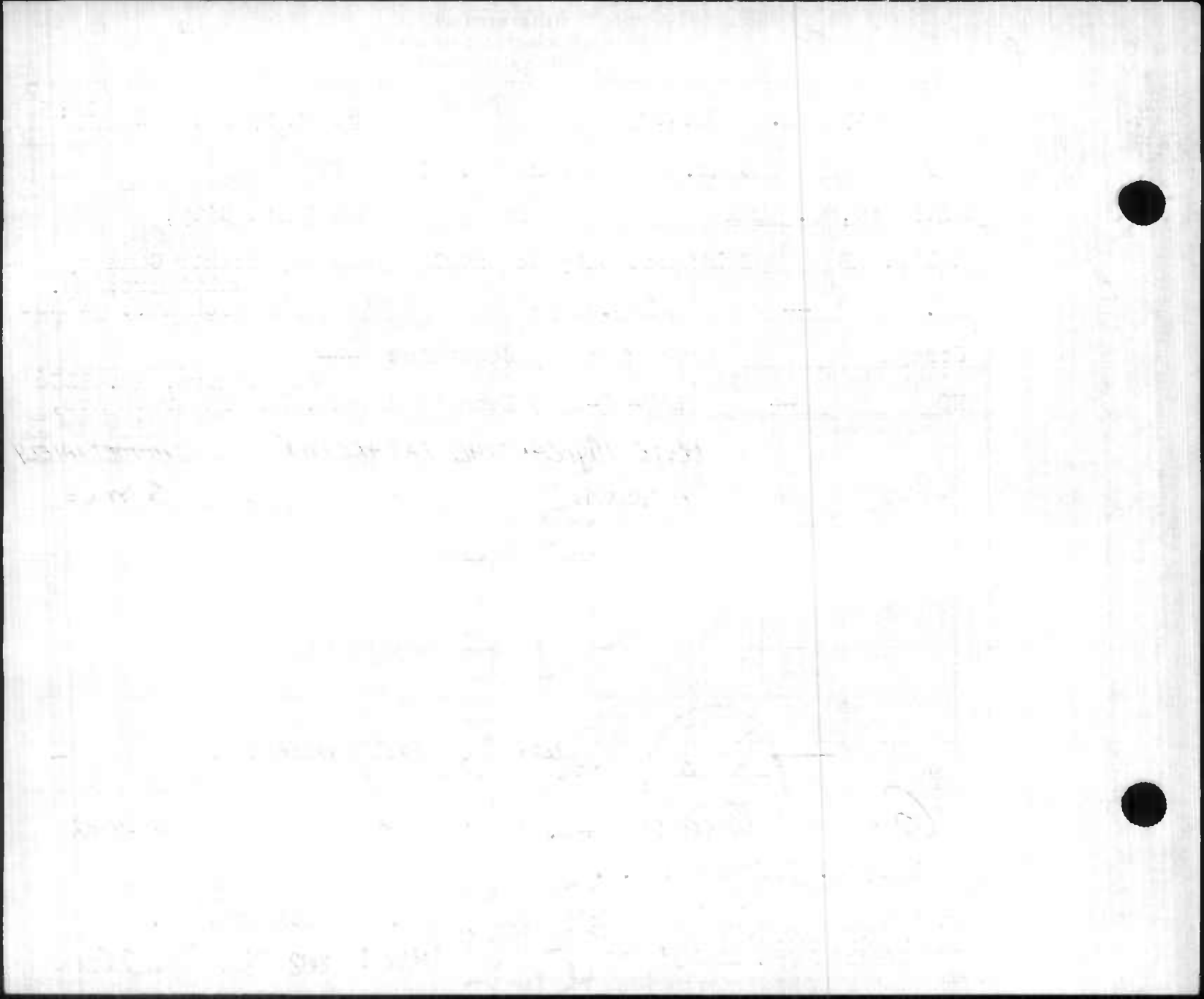
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours of death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified in advance.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 2 0 3 5 2 5

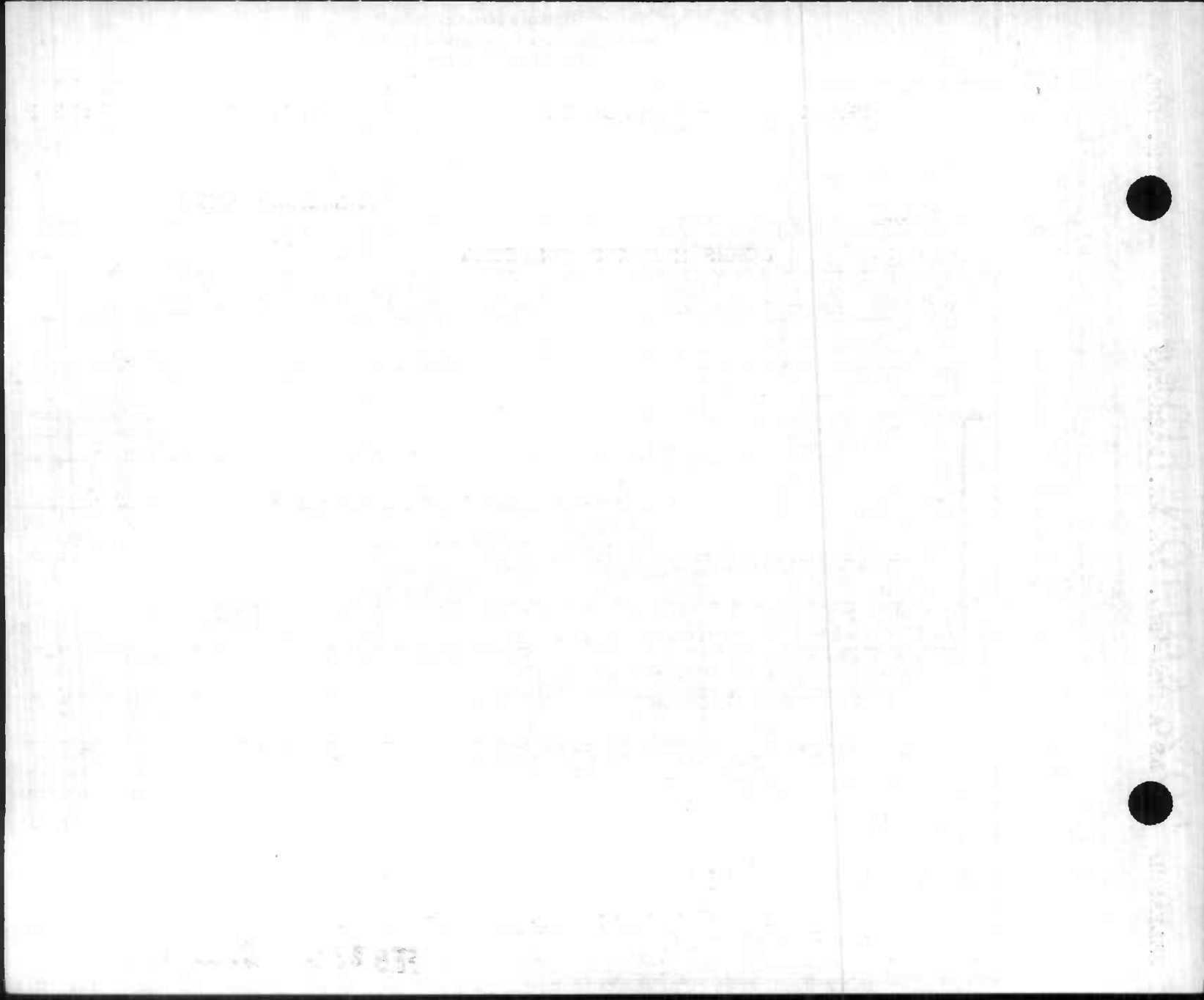
1. FOR STATE REGISTRAR		2a. DATE OF DEATH		2b. HOUR	
1. DECEASED NAME (TYPE OR PRINT)		MONTH DAY YEAR		P M	
FIRST MIDDLE LAST		February 23, 1982		10:15	
Mary A. Banack					
3. SEX	4. RACE	5. DATE OF BIRTH	6. AGE (IN YEARS LAST BIRTHDAY)	IF UNDER 1 YEAR	
F	Cauc.	MONTH DAY YEAR	83	YRS. MONTHS DAYS HOURS MIN.	
		June 15, 1898			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH		
Baltimore, MD.	USA		Baltimore City, MD.		
10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)	12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)	12b. KIND OF BUSINESS OR INDUSTRY		
Balto, MD	Baltimore City Hospital	Factory Worker	Cannery		
13a. STATE		13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS?	13e. STREET ADDRESS
MD.	--	Balto. City	YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		Baltimore, MD. 4434 Shamrock Ave. 21206
14. FATHER'S NAME		15. MOTHER'S MAIDEN NAME			
FIRST MIDDLE LAST		FIRST MIDDLE LAST			
Joseph Antkowiak		Josephine ---			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO.	17. INFORMANT		
NO		217-03-2565	Baltimore, Md. 21206 Leonard Banack, 4424 Shamrock Ave.		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY:					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
IMMEDIATE CAUSE (a) <u>4100</u> <u>FLUTE MYOCARDIAL INFARCTION</u>					<u>IMMEDIATELY</u>
DUE TO, OR AS A CONSEQUENCE OF (b) <u>A.S.C.V.D.</u>					<u>2 mos.</u>
DUE TO, OR AS A CONSEQUENCE OF (c) _____					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY?	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
				YES <input type="checkbox"/> NO <input type="checkbox"/>	YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)	
		P.M. 19			
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (the hospital) attended the deceased from <u>1/28</u> , 19 <u>82</u> , to <u>present</u> , 19 _____ that (I) (we) last saw the deceased alive on <u>FEB 12</u> , 19 <u>82</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE				DEGREE	22c. DATE SIGNED
<u>Barry J. Weckesser</u>				ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>	<u>2-24-82</u>
22d. PHYSICIAN'S NAME (TYPE OR PRINT)				22e. ADDRESS	
Barry J. Weckesser, M.D.					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION CITY OR TOWN COUNTY STATE	
Burial		2/27/82	Holy Rosary Cem.	Baltimore, Md.	
24. FUNERAL DIRECTOR		25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE	
Schumacher Funeral Home, 3331 Brehms La. Baltimore, Md. 21213		MAR 1 1982		<u>Harcos Jan Nathan</u>	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 must be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed in the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH									
1. FOR STATE REGISTRAR									
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Francis J. BANCEWICZ, Sr.						2a. DATE OF DEATH MONTH DAY YEAR 2/20/82		2b. HOUR 1:22 PM	
3. SEX Male		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR 9 12 1927		6. AGE (IN YEARS LAST BIRTHDAY) 54 YRS.		7. IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE CITY MD.			
10. CITY OR TOWN OF DEATH Baltimore		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) JOHNS HOPKINS HOSPITAL				12. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Shipyard Worker		12b. KIND OF BUSINESS OR INDUSTRY Beth. Steel	
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)									
13a. STATE Maryland		13b. COUNTY Baltimore		13c. CITY OR TOWN Dundalk		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS 8071 Park Haven Road	
14. FATHER'S NAME FIRST MIDDLE LAST Frank Bancewicz				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Sophia Matuszak					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) Yes WW II				16b. SOCIAL SECURITY NO. 219-22-6149		17. INFORMANT 8071 Park Haven Rd. - Balto., MD. 21222 Bernadette R. Bancewicz			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CARDIORESPIRATORY arrest 4275 DUE TO, OR AS A CONSEQUENCE OF (b) low cardiac output syndrome DUE TO, OR AS A CONSEQUENCE OF (c) CORONARY artery bypass								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 5 min 10 min 1 hour	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) None									
19a. DATE OF OPERATION Feb 20, 1982		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED CARDIOGENIC shock				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from Feb 16 , 19 82 , to Feb 20 , 19 82 , that (I) (we) lost saw the deceased alive on Feb 20 , 19 82 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE Walter H. Merrill				DEGREE M.O. ATTENDING MEDICAL STAFF PHYSICIAN <input type="checkbox"/> DIRECTOR <input type="checkbox"/> PHYSICIAN <input type="checkbox"/>				22c. DATE SIGNED Feb 20, 1982	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Walter H. Merrill				22e. ADDRESS Johns Hopkins Hospital					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 2/24/1982		23c. NAME OF CEMETERY OR CREMATORY St. Stanislaus		23d. LOCATION CITY OR TOWN COUNTY STATE Baltimore Maryland			
24. FUNERAL DIRECTOR NAME ADDRESS Duda-Ruck, Inc. 7922 Wise Avenue Dundalk, MD. 21222						25. DATE REC'D. BY REGISTRAR FEB 23 1982		26. REGISTRAR'S SIGNATURE <i>[Signature]</i>	



TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours of death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

8 2 0 3 5 2 7

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Eugene W. Banks				2a. DATE OF DEATH MONTH DAY YEAR 2 5 1982		2b. HOUR M M	
3. SEX male		4. RACE black		5. DATE OF BIRTH MONTH DAY YEAR 6 26 1910		6. AGE (IN YEARS LAST BIRTHDAY) 71 YRS	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Md		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore city MD.	
10. CITY OR TOWN OF DEATH Baltimore		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 501 Dolphin Street				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Baltimore city	
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Md				13b. COUNTY Baltimore		13c. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST Walker Banks				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Jella Green			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. N/A		17. INFORMANT ADDRESS Leatha Mae Fogg 4204 Harford Terrace			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: 4249 IMMEDIATE CAUSE (a) Caraccie arrest DUE TO, OR AS A CONSEQUENCE OF (b) voluntarily heart disease Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) _____							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) Chronic obstructive pulmonary disease							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from 2 NOV 19 81 to 19 82 , that (I) (we) last saw the deceased alive on 2 NOV 19 81 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) did not view the body after death.							
22b. SIGNATURE Frederick Sutton				DEGREE MD		22c. DATE SIGNED 2/8/82	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) FREDERICK SUTTON				22e. ADDRESS 22 S GREEN ST BALTIMORE 21201			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 2/10/82		23c. NAME OF CEMETERY OR CREMATORY Mt Auburn Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE Baltimore	
24. FUNERAL DIRECTOR NAME William C. March F/H 1101 E. North Avenue				25a. DATE REC'D. BY REGISTRAR (25b. REGISTRAR'S SIGNATURE) FEB 9 1982 Charles J. Huthorn			

with 1000 ft. 200

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, THE EXAMINER SHOULD WRITE "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. GIVE PAGE 4 TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR RECORDS. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 24 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

FOR
1- STATE
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT)		FIRST	MIDDLE	LAST	2a. DATE KNOWN OF DEATH ESTIMATED		<input checked="" type="checkbox"/> MONTH	DAY	YEAR	2b. HOUR	
MELVIN T. BANKS					2-10-82		19			M	
3. SEX	4. RACE	5. DATE OF BIRTH MONTH DAY YEAR		6. AGE (IN YEARS) LAST BIRTHDAY	IF UNDER 1 YR. MONTHS DAYS	IF UNDER 24 HRS. HOURS MIN.	7c. DATE PRONOUNCED DEAD		MONTH DAY YEAR	2d. HOUR	
male	black	10 3 35		46 YRS.			2-10-82		19	7:25P M	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH					
MD		USA				Baltimore City		MD			
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY			
Baltimore		Lutheran Hospital									
13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS			
MD				Baltimore				1133 Woodyear St.			
14. FATHER'S NAME FIRST MIDDLE LAST		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)		16b. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS			
Richard Banks, Sr.		Thelma Johnson		No		213-34-3614		Shirley Banks 2424 Darton Ct. Jerome Banks 2206 Roslyn Ave.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Arteriosclerotic cardiovascular disease</u> DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause lost.										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?						20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION CITY OR TOWN COUNTY STATE							
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> .											
ACTUAL SIGNATURE		TITLE (SPECIFY)				DATE SIGNED					
Margarita A. Koroll, M.D.		M.D. Assistant MEDICAL EXAMINER				2-11-82					
EXAMINER'S NAME (TYPE OR PRINT)		ADDRESS									
Margarita A. Koroll, M.D.		111 Penn Street									
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION CITY OR TOWN		COUNTY		STATE	
Burial		2/15/82		King Memorial Park		Baltimore		Co.		MD	
24. FUNERAL DIRECTOR NAME		ADDRESS		25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE					
Wm. C. March F/H		1101 E. North Ave.		FEB 16 1982		[Signature]					

BP

DHM-17
(VR A15 ME (5))
15M2/80

1875-1876



STATE OF MARYLAND

DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 2 0 3 5 3 0

1. FOR
STATE
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST FRANCIS J. BARRETT			2a. DATE OF DEATH MONTH DAY YEAR 2 10 82		2b. HOUR 240/P.M.				
3. SEX MALE		4. RACE CAUCASIAN		5. DATE OF BIRTH MONTH DAY YEAR 3 04 22		6. AGE (IN YEARS LAST BIRTHDAY) YRS. 59		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MARYLAND		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE CITY MD.			
10. CITY OR TOWN OF DEATH BALTIMORE MD.		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) SOUTH BALTO. GEN. HOSP.				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Car Inspector		12b. KIND OF BUSINESS OR INDUSTRY R.R.	
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)									
13a. STATE MARYLAND		13b. COUNTY H.A.		13c. CITY OR TOWN PASADENA		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS 330 BAR HARBOR RD.	
14. FATHER'S NAME FIRST MIDDLE LAST ANTHONY --- BARRETT			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST CATHERINE --- BROGEN						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) YES W.W. 2			16b. SOCIAL SECURITY NO. 213-12-4929		17. INFORMANT ADDRESS Timothy J. Barrett, Same as above				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) RESPIRATORY FAILURE 1629 DUE TO, OR AS A CONSEQUENCE OF (b) METASTATIC OAT CELL CARCINOMA DUE TO, OR AS A CONSEQUENCE OF (c) 7 mos.								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 24-48 hrs.	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)									
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from 2/9/82 , 19 82 , to 2/10 , 19 82 , that (I) (we) lost saw the deceased alive on 2/10 , 19 82 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE Roy Cragway Jr. M.D.			DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22c. DATE SIGNED 2/10/82			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) ROY CRAGWAY JR. M.D.			22e. ADDRESS 3001 SOUTH HANOVER ST						
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE Feb. 13, 1982		23c. NAME OF CEMETERY OR CREMATORY Cedar Hill Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE Baltimore, Maryland		
24. FUNERAL DIRECTOR NAME McCutty Funeral Home, 130 E. Forest Ave. Balto. Md.					25a. DATE REC'D. BY REGISTRAR FEB 16 1982				
					25b. REGISTRAR'S SIGNATURE Anne J. Smith				

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. It may be returned by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the informant on page 2, should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the Department of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP

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TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 1B shows any injury, or other traumatic event, the medical examiner must be notified or called.

1. FOR STATE REGISTRAR		STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				REG. NO. 8 2 0 3 5 3 1					
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST VOLA P. BARTON						2a. DATE OF DEATH MONTH DAY YEAR 2 12 82				2b. HOUR 2:00 P.M.	
3 SEX Female		4 RACE White		5. DATE OF BIRTH MONTH DAY YEAR 12 19 93		6 AGE (IN YEARS LAST BIRTHDAY) YRS. 88		IF UNDER 1 YEAR MONTHS DAYS 		IF UNDER 24 HRS. HOURS MIN. 	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Md.		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Balto. City MD.					
10. CITY OR TOWN OF DEATH Balto.		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 3811 Canterbury Road				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Professor		12b. KIND OF BUSINESS OR INDUSTRY Education			
13a. STATE Md.		13b. COUNTY Balto.		13c. CITY OR TOWN Balto.		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 3811 Canterbury Road			
14. FATHER'S NAME FIRST MIDDLE LAST James Sheridan Barton						15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Mary Irene Eichelberger					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. 220-30-3765		17. INFORMANT ADDRESS Irene Mitchell Ft. Lauderdale, Fla.							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Vascular Accident 4029 DUE TO, OR AS A CONSEQUENCE OF (b) Hypertensive Cardio Vascular Disease Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO, OR AS A CONSEQUENCE OF (c) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 10 Days 12 years											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)											
19a. DATE OF OPERATION 				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED 				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1B PART 1 OR PART 2) 					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) 		21f. LOCATION STREET CITY OR TOWN COUNTY STATE 					
22a. I certify that (I) (this hospital) attended the deceased from December 16, 1976 to February 12, 1982 , that (I) (we) lost saw the deceased alive on 19 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE W. Grafton Hersperger 22b. PHYSICIAN'S NAME (TYPE OR PRINT)				DEGREE M.D. 22c. DATE SIGNED 2/17/82				ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			
22e. ADDRESS W. Grafton Hersperger, M. D.				22f. ADDRESS 214 Med. Arts Bldg. Baltimore, Md. 21201							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Removal		23b. DATE 2/12/82		23c. NAME OF CEMETERY OR CREMATORY 		23d. LOCATION CITY OR TOWN COUNTY STATE 					
24. FUNERAL DIRECTOR NAME Anatomy Board				ADDRESS Balto., Md.				25a. DATE REC'D. BY REGISTRAR FEB 26 1982		25b. REGISTRAR'S SIGNATURE 	

James

Shenigan

Thurston

Wray

Thorne

Lowmeyer

200-27-2722

James Michael, Jr., Treasurer, etc.

Also

2011 Corporation and

Shenigan

Shenigan

Mr.

Also

201 Corporation and

Mr.

U.S.A.

Also

James

Wray

201 Corporation and

Shenigan

Also

Also

201 Corporation and

Shenigan

TO HOSPITAL OR ATTENDING PHYSICIAN. The low requires that the death certificate be executed within 24 hours after death. Page 4 of 4.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical

1- FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

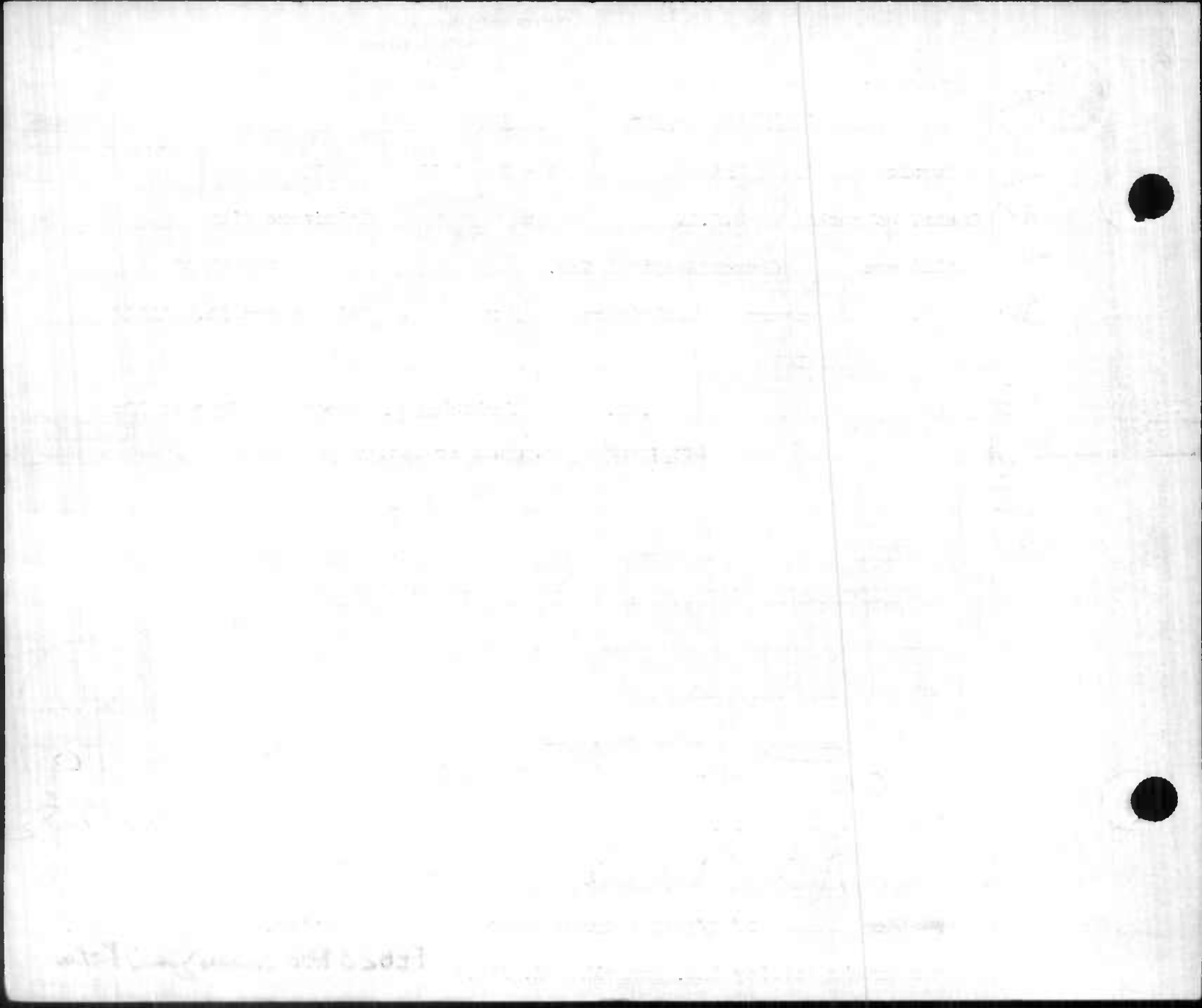
8 2 0 3 5 3 2

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) CHRISTINE ANNE BASARA			2a. DATE OF DEATH MONTH DAY YEAR 02-19-82		2b. HOUR 3:00pm	
3. SEX Female		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR 3 - 2 - 1911		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Omaha, Nebraska		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		6. AGE (IN YEARS LAST BIRTHDAY) YRS. MONTHS DAYS HOURS MIN. 70		
10. CITY OR TOWN OF DEATH Baltimore		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Church Hospital Inc.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		
13a. STATE Md.		13b. COUNTY -----		13c. CITY OR TOWN Baltimore		
14. FATHER'S NAME FIRST MIDDLE LAST UNKNOWN		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST UNKNOWN		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City MD.		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 507.03.4353		17. INFORMANT ADDRESS Christine A. Basara - Same as 13e		
18. CAUSE OF DEATH: Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) METASTATIC CARCINOMA OF BREAST 1749 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____						
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a) ARTERIOSCLEROTIC CARDIOVASCULAR DISEASE, DIABETES MELLITUS						
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)		
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE		
22a. I certify that (1) this hospital attended the deceased from 02-17- 19 82 , to 02-19- 19 82 , that (1) we lost saw the deceased alive on 02-19- 19 82 , and that in (my) our opinion death occurred on the date and hour and from the causes stated above, (if we did) (did not) view the body after death.						
22b. SIGNATURE AHMED F. NOUR, M.D.				22c. DATE SIGNED 2-19-82		
22d. PHYSICIAN'S NAME (TYPE PRINT) AF NOUR MD				22e. ADDRESS CHURCH HOSPITAL CORPORATION 100 N. BROADWAY BALTIMORE, MARYLAND 21231		
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Cremation		23b. DATE 2/20/1982		23c. NAME OF CEMETERY OR CREMATORY Green Mount		
24. FUNERAL DIRECTOR NAME Walter Brooks Bradley Inc. Dundalk, Md. 21222		23d. LOCATION CITY OR TOWN COUNTY STATE Balto. Md.		25a. DATE REC'D. BY REGISTRAR FEB 23 1982		

REGISTRAR'S SIGNATURE

Frances Santhron



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified or called.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 2 0 3 5 3 3

1- FOR
STATE
REGISTRAR

REG. NO.

1 DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST AGNES C. BASCHKE			2a DATE OF DEATH MONTH DAY YEAR 2-11-82			2b HOUR 3:08 PM	
3 SEX FEMALE		4 RACE WHITE		5 DATE OF BIRTH MONTH DAY YEAR 03 23 01		6 AGE (IN YEARS LAST BIRTHDAY) YRS. MONTHS DAYS HOURS MIN. 80	
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) CANADA		7b CITIZEN OF WHAT COUNTRY? U.S.A.		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE CITY MD.	
10 CITY OR TOWN OF DEATH BALTIMORE		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) ST. AGNES HOSPITAL				12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) HOMEMAKER	
13a STATE MARYLAND		13b COUNTY ---		13c CITY OR TOWN BALTIMORE		13d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14 FATHER'S NAME FIRST MIDDLE LAST UNKNOWN		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST UNKNOWN		13e STREET ADDRESS 225 OAKLEE VILLAGE, 21229			
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO		16b SOCIAL SECURITY NO. 216-52-0638		17 INFORMANT ADDRESS BERNARD W. SANDERS 5002 REMMELL AVE. 21206			
18 CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiorespiratory arrest 1539 DUE TO, OR AS A CONSEQUENCE OF (b) Metastatic Carcinomatous Process DUE TO, OR AS A CONSEQUENCE OF (c) Cancer of Colon							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: Septicemia							
19a DATE OF OPERATION ---		19b CONDITION FOR WHICH OPERATION WAS PERFORMED ---		20a AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) ---			
21d INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f LOCATION STREET CITY OR TOWN COUNTY STATE			
22a I certify that (I) (this hospital) attended the deceased from 1/31/82 to 2/11/82 that (I) (we) last saw the deceased alive on 2/11/82 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above; (I) (we) (did) (did not) view the body after death.							
22b SIGNATURE Amar N. Sarwal DEGREE MD						22c DATE SIGNED 2/11/82	
22d PHYSICIAN'S NAME (TYPE OR PRINT) AMAR N. SARWAL				22e ADDRESS St. Agnes Hospital			
23a BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL		23b DATE 02-13-82		23c NAME OF CEMETERY OR CREMATORY MOST HOLY REDEEMER		23d LOCATION CITY OR TOWN COUNTY STATE BALTIMORE CITY MARYLAND	
24 FUNERAL DIRECTOR NAME HUBBARD FUNERAL HOME, INC.				ADDRESS 21229 4107 WILKENS AVE.		25a DATE REC'D. BY REGISTRAR FEB 16 1982	
						25b REGISTRAR'S SIGNATURE James J. [Signature]	

(1)

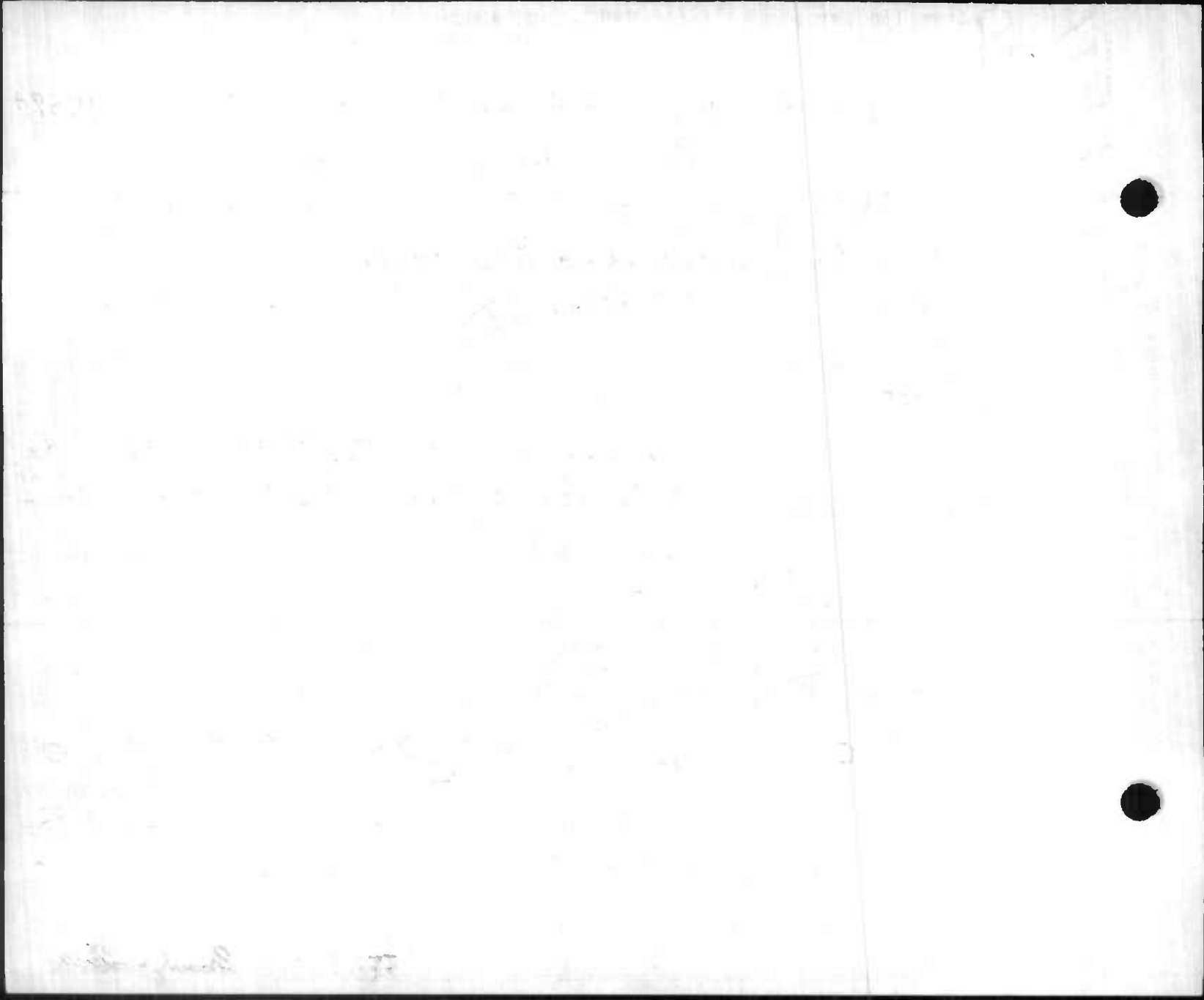
(2)



Item 13e per phone 3/2/82 dad STATE OF MARYLAND
 DEPARTMENT OF HEALTH AND MENTAL HYGIENE 8 2 0 3 5 3 4
 CERTIFICATE OF DEATH

1. DECEASED NAME (TYPE OR PRINT) VIOLA E. BASKET		2a. DATE OF DEATH MONTH DAY YEAR FEB. 19, 1982		2b. HOUR 11:59^{AM}	
3. SEX F	4. RACE B	5. DATE OF BIRTH MONTH DAY YEAR 6/16/26		6. AGE (IN YEARS LAST BIRTHDAY) 55 YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MD.	7b. CITIZEN OF WHAT COUNTRY? U.S.A.	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH BALTO. CITY MD	
10. CITY OR TOWN OF DEATH BALTO.	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Good Samaritan Hosp.		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Babysitter		12b. KIND OF BUSINESS OR INDUSTRY
13a. STATE MD.	13b. COUNTY	13c. CITY OR TOWN Balto.	13d. INSIDE CITY LIMITS YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET ADDRESS 814 N. Stricker St.	
14. FATHER'S NAME FIRST MIDDLE LAST James Allen		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Dorothy Brooks			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO		16b. SOCIAL SECURITY NO. N/A		17. INFORMANT ADDRESS Doris Matthews 1736 E. Eager St.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY 4100 IMMEDIATE CAUSE (a) massive heart attack 30 MIN. DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) arteriosclerotic heart disease several years DUE TO, OR AS A CONSEQUENCE OF (c)					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a) diabetes					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (i) (this hospital) attended the deceased from 2/19/82 to 2/19/82 , that (i) we lost saw the deceased alive on 2/19/82 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (i) (we) (did) (did not) view the body after death.					
22b. SIGNATURE Dr. Stewart, M.D.		DEGREE M.D.		22c. DATE SIGNED 2/19/82	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) D. W. STEWART		22e. ADDRESS 2300 Garrison Blvd.			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 2/25/82		23c. NAME OF CEMETERY OR CREMATORY Md. Veteran Cem.	
23d. LOCATION CITY OR TOWN Crownsville		COUNTY		STATE MD	
24. FUNERAL DIRECTOR NAME Wm. C. March F/H		ADDRESS 1101 E. North Ave.		25a. DATE REC'D. BY REGISTRAR FEB 23 1982	
				25b. REGISTRAR'S SIGNATURE Thomas J. Matthews	

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. The certificate must be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
 IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.



TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM-3. RETAIN PAGES 1 AND 2 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED IN DIVISION 73 STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

DHMH - 17
(VR A15 ME (5))
15M 2/80

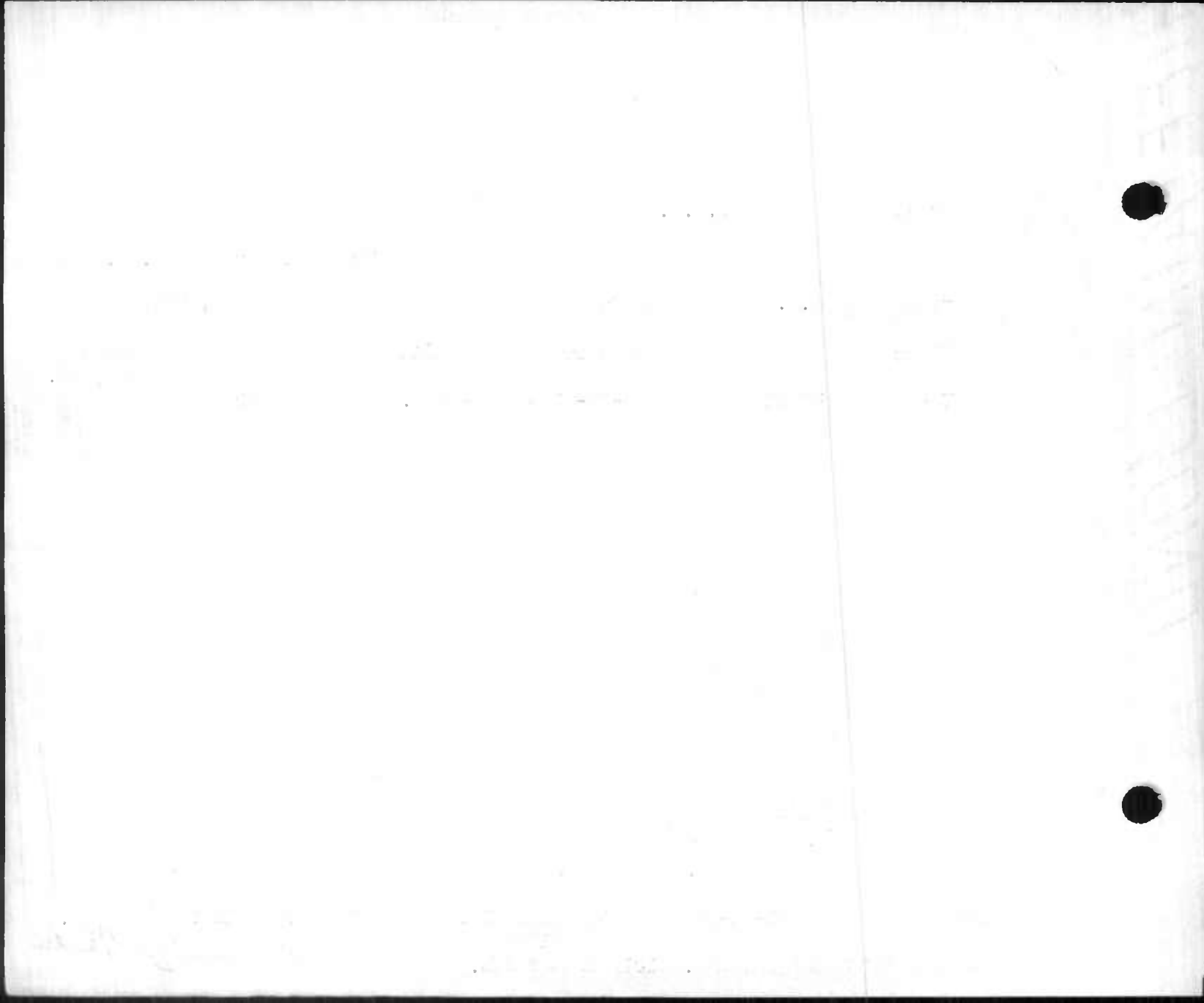
STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

1- FOR
STATE
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT)		FIRST	MIDDLE	LAST	2a. DATE KNOWN OF DEATH		XX	MONTH	DAY	YEAR	2b. HOUR
Elmer Andrew Bassler					2			28	19	82	M
3. SEX	4. RACE	5. DATE OF BIRTH		6. AGE (IN YEARS)	IF UNDER 1 YR.	IF UNDER 24 HRS.	7c. DATE PRONOUNCED DEAD		MONTH	DAY	YEAR
male	white	07 21 23		58 YRS.	MONTHS	DAYS	2 28 1982		4:06P		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH					
Maryland		U.S.A.		WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		Baltimore City		MD			
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY			
Baltimore		University Hospital				Truck Driver		A. S. Abell			
USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)											
13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?		13e. STREET ADDRESS			
Maryland		A.A.		Pasadena		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		8423 Bay Road, 21122			
14. FATHER'S NAME				15. MOTHER'S MAIDEN NAME							
FIRST MIDDLE LAST				FIRST MIDDLE LAST							
Elmer Bassler				Elsie Unknown							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)				16b. SOCIAL SECURITY NO.		17. INFORMANT		ADDRESS			
Yes				WW II		216-12-9384		HELEN V. BASSLER 8423 Bay Road			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: 4292 IMMEDIATE CAUSE (a) <u>Arteriosclerotic cardiovascular disease</u> DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____											APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1											
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?						20. AUTOPSY?	
										YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that I took charge of the remains described above, held on death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion											
ACTUAL SIGNATURE <u>Hormez R. Guard</u>				TITLE (SPECIFY) Assistant				DATE SIGNED 3/1/82			
EXAMINER'S NAME (TYPE OR PRINT)				ADDRESS							
Hormez R. Guard, M.D.				111 Penn Street, Balto. MD 21201							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION CITY OR TOWN COUNTY STATE					
ENTOMBMENT		03-04-82		MORELAND MEMORIAL PARK		HILLENDALE BALTIMORE MD.					
24. FUNERAL DIRECTOR NAME ADDRESS				25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE					
HUBBARD FUNERAL HOME, INC. 4107 WILKENS AVE.				21229		MAR 3 1982		Frances Jan Nathan			

BP



STATE OF MARYLAND

DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 2 0 3 5 3 6

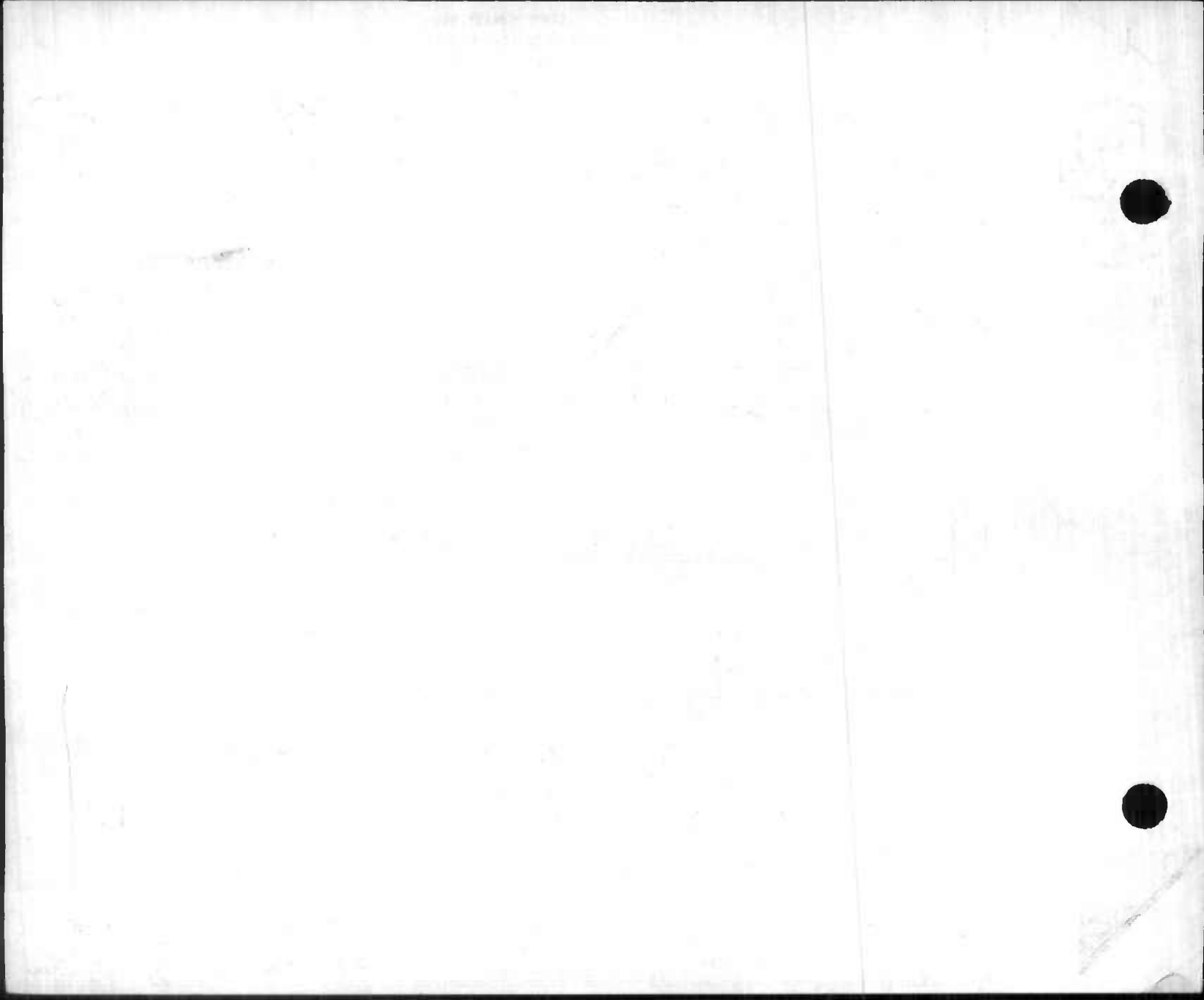
1 - FOR
STATE
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) Leonard J. BATEMAN, SR.			2a. DATE OF DEATH MONTH 2 DAY 12 YEAR 82		2b. HOUR 6 PM
3. SEX Male	4. RACE white	5. DATE OF BIRTH MONTH 9 DAY 29 YEAR 25		6. AGE (IN YEARS, LAST BIRTHDAY) 56	IF UNDER 1 YEAR MONTHS 0 DAYS 0
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MD		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH Balto City
10. CITY OR TOWN OF DEATH Balto		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) South Balto General		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Cannery Builder of Employed	
13a. STATE MD		13b. COUNTY Balto	13c. CITY OR TOWN Balto	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET ADDRESS 2123 Hollins Ferry Rd
14. FATHER'S NAME FIRST William MIDDLE BATEMAN		15. MOTHER'S MAIDEN NAME FIRST Laura MIDDLE Hyles		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) Yes	
16b. SOCIAL SECURITY NO. 219 16 3126		17. INFORMANT Lula Bateman		ADDRESS 3123 Hollins Ferry Rd. 21230	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pneumonia etiology unknown 4960 DUE TO, OR AS A CONSEQUENCE OF (b) Chronic Obstructive Pulmonary Disease DUE TO, OR AS A CONSEQUENCE OF (c) Embolus (R) femoral Artery					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 6 wks 6 yrs
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) Pneumothorax & cardiac arrest after diagnostic bronchoscopy					
19a. DATE OF OPERATION 2/10/82		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED Pulmonary Infiltrates etiology unk		20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from 1/15/82 , 19____, to 2/12/82 , 19____, that (I) (we) last saw the deceased alive on 2/12/82 , 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE Richard A. Baum MD		DEGREE MD		22c. DATE SIGNED 2/12/82	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Richard A. Baum MD		22e. ADDRESS University of Maryland Hospital			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 2-17-1982		23c. NAME OF CEMETERY OR CREMATORY The Vet Cem.	
23d. LOCATION (CITY OR TOWN) COUNTY STATE Crownsville Ind.		24. FUNERAL DIRECTOR NAME James Crown & Son, Inc. ADDRESS Balto, Md. 21223 901 Hollins St.			
25a. DATE REC'D. BY REGISTRAR FEB 17 1982		25b. REGISTRAR'S SIGNATURE James Santhorn			

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon copies. Pages 1 and 2 should be filed with the health department after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

Item 13b per phone 2/10/82 dad

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

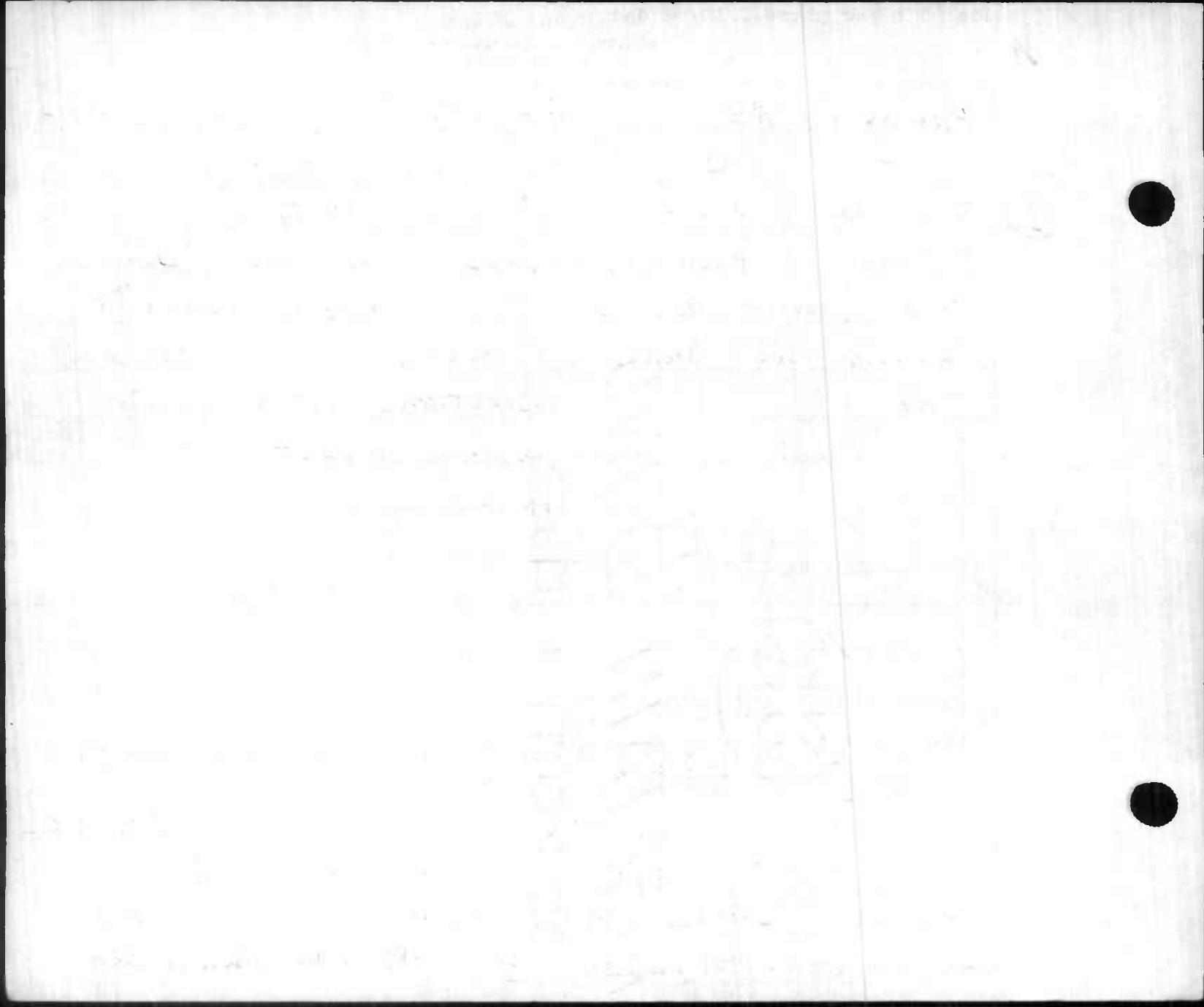
8 2 0 3 5 3 7

1- FOR
STATE
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FRANCES FRANCES BATES				2a. DATE OF DEATH MONTH DAY YEAR 2-3-82				2b. HOUR 10 11A	
3. SEX F		4. RACE B		5. DATE OF BIRTH MONTH DAY YEAR 12 01 39		6. AGE (IN YEARS LAST BIRTHDAY) 42 YRS		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) BALTO. Md.		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH CITY BALTO. MD			
10. CITY OR TOWN OF DEATH BALTO		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF IN SUCH FACILITY, GIVE STREET ADDRESS) BALTO CITY HOSPITAL				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Assist Sup.		12b. KIND OF BUSINESS OR INDUSTRY Human Resources	
13a. STATE Md.		13b. COUNTY Harford		13c. CITY OR TOWN Edgewood		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 1585 Charles Town Dr.	
14. FATHER'S NAME FIRST MIDDLE LAST FRANCIS Lee Thompson				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST KATIE Brown					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES)		17. INFORMANT CARL BATES		ADDRESS 1585 Charles Town Dr.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: 0389 IMMEDIATE CAUSE (a) Cardiopulmonary arrest DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Sepsis DUE TO, OR AS A CONSEQUENCE OF (c)									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (c): Metastatic Breast Cancer									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (1) this hospital attended the deceased from 12-30-81 to 2-3-82 , that (1) we lost saw the deceased alive on 2-3-82 , and that in my (our) opinion death occurred on the date and hour and from the causes stated above (2) we (did) did not view the body after death.									
22b. SIGNATURE W. Dombrowski MD				DEGREE				22c. DATE SIGNED 2-3-82	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) WM DOMBROWSKI				22e. ADDRESS Balto City Hosp.					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 2-8-82		23c. NAME OF CEMETERY OR CREMATORY Md. NAT Mem Pk.		23d. LOCATION CITY OR TOWN COUNTY STATE LAUREL Md.			
24. FUNERAL DIRECTOR NAME JAS. A. MORTON				ADDRESS 1701 LAURENS ST		25a. DATE REC'D. BY REGISTRAR FEB 4 1982		25b. REGISTRAR'S SIGNATURE <i>James J. Morton</i>	

BP



TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled within 72 hours of death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be called at once.

Item #23b per phone call w/Fun. Home

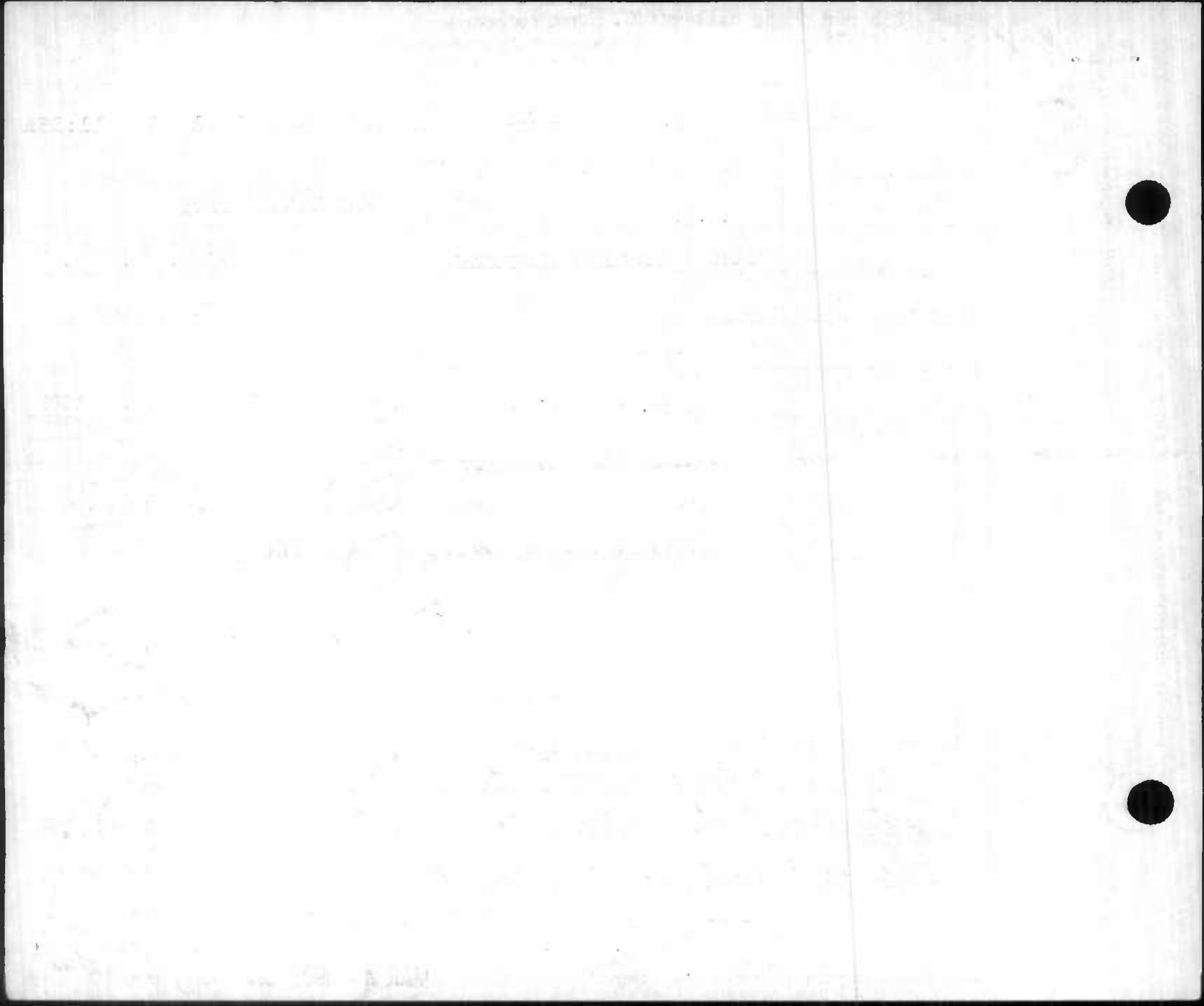
 1. FOR STATE REGISTRAR
3/8/82 rc

 STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 2 0 3 5 3 8

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST MARLENE R. BATOFF			2a. DATE OF DEATH MONTH DAY YEAR FEBRUARY 26, 1982		2b. HOUR 11:35A
3. SEX FEMALE	4. RACE CAUCASIAN	5. DATE OF BIRTH MONTH DAY YEAR JULY 12, 1950		6. AGE (IN YEARS LAST BIRTHDAY) 31 YRS	IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MARYLAND	7b. CITIZEN OF WHAT COUNTRY? U.S.A.	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE CITY MD.	
10. CITY OR TOWN OF DEATH BALTIMORE	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) JOHNS HOPKINS HOSPITAL		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) TEACHER		12b. KIND OF BUSINESS OR INDUSTRY BALTO. CO. PUB.
13a. STATE MARYLAND	13b. COUNTY BALTIMORE	13c. CITY OR TOWN BALTIMORE	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	13e. STREET ADDRESS 6818 NAVAJO DR. #21209	
14. FATHER'S NAME FIRST MIDDLE LAST JOSEPH PAUL		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST SHIRLEY FOX			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO		16b. SOCIAL SECURITY NO. 219-58-2645		17. INFORMANT ADDRESS MR. STEVEN I. BATOFF 6818 NAVAJO DR. #21209	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Respiratory arrest</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) <u>Pulmonary infiltrates</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>metastatic breast cancer</u>					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>minutes</u> <u>clump</u> <u>1980</u>
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <u>1749</u>					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from <u>2/23</u> , 19 <u>82</u> , to <u>2/26</u> , 19 <u>82</u> , that (I) (we) lost saw the deceased alive on <u>2/26</u> , 19 <u>82</u> , and that (I) (my) (our) opinion death occurred on the date and hour and from the causes stated above. (If (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE <u>Steven P Scholman</u>		DEGREE <u>MD</u>		22c. DATE SIGNED <u>2/26/82</u>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <u>Steven P Scholman</u>		22e. ADDRESS <u>601 W. Broadway Baltimore</u>			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL		23b. DATE 2-26-82	23c. NAME OF CEMETERY OR CREMATORY SHAAREI TFILOH CONG.		23d. LOCATION CITY OR TOWN COUNTY STATE BALTIMORE MD
24. FUNERAL DIRECTOR NAME SOL LEVINSON & BROS., INC.			25a. DATE REC'D BY REGISTRAR MAR 4 1982		
6010 REISTERSTOWN RD., BALTO., MD 21215			25b. REGISTRAR'S SIGNATURE <u>Thomas J. Nathan</u>		



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										REG. NO. 8 2 0 3 5 3 9			
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST GEORGE R. BATTERSBY SR.										2a. DATE OF DEATH MONTH DAY YEAR FEBRUARY 28, 1982		2b. HOUR 12:04am	
3. SEX Male		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR April 12 1905		6. AGE (IN YEARS LAST BIRTHDAY) 76 YRS.		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Baltimore		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City MD.							
10. CITY OR TOWN OF DEATH Baltimore		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Church Hospital				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Supervisor		12b. KIND OF BUSINESS OR INDUSTRY City Parks					
13a. STATE Maryland		13b. COUNTY ---		13c. CITY OR TOWN Baltimore		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 423 S. Robinson St.					
14. FATHER'S NAME FIRST MIDDLE LAST George Battersby				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Laura G. Sullivan									
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) no		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 217-03-7812		17. INFORMANT ADDRESS Mary Battersby 423 S. Robinson St.									
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CARDIOPULMONARY ARREST 4149 DUE TO, OR AS A CONSEQUENCE OF (b) CORONARY HEART DISEASE Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last } DUE TO, OR AS A CONSEQUENCE OF (c) ARTERIOSCLEROSIS													
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)													
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)									
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE									
22a. I certify that (a) (this hospital) attended the deceased from 19 77 to FEB. 21 19 82 , that (b) (we) lost saw the deceased alive on FEB. 20 19 82 , and that in (c) (my) (our) opinion death occurred on the date and hour and from the causes stated above (d) (we) (did) (did not) view the body after death.													
22b. SIGNATURE <i>Thelito Torres</i>				DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>				22c. DATE SIGNED					
22d. PHYSICIAN'S NAME (TYPE OR PRINT) THELITO, TORRES MD.				22e. ADDRESS CHURCH HOME CORP. 100 N. BROADWAY BALTIMORE, MD; 21231									
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE March 3 1982		23c. NAME OF CEMETERY OR CREMATORY Sacred Heart of Jesus		23d. LOCATION CITY OR TOWN COUNTY STATE Baltimore Maryland							
24. FUNERAL DIRECTOR NAME ADDRESS Lilly & Zeiler, Inc. 700 S. Conkling St.						25a. DATE REC'D. BY REGISTRAR MAR 1 1982		25b. REGISTRAR'S SIGNATURE <i>Thomas J. ...</i>					

Male

White

April 12 1905

78

Baltimore

U.S.A.

X

Baltimore City

Baltimore

Church Hospital

Superintendent

City of Baltimore

Maryland

Baltimore

X

St. John's St.

George

Hospital

Island

C.

Sullivan

no

St. John's St.

Maryland St. John's St.

Island

March 3 1905

BAR 1

St. John's St. John's St.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. It may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										REG. NO. 6203540	
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST ALICE P. MILLS McGuire BAYLOR						2a. DATE OF DEATH MONTH DAY YEAR February 16, 1982			2b. HOUR 7:30 P.M.		
3. SEX Female		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR Oct. 31, 1906		6. AGE (IN YEARS LAST BIRTHDAY) 75 YRS.		7. IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.		8. IF UNDER 24 HRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City MD					
10. CITY OR TOWN OF DEATH Baltimore		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 5912 Meadowood Road				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Teacher - Public Schools			12b. KIND OF BUSINESS OR INDUSTRY		
13a. STATE Maryland		13b. COUNTY		13c. CITY OR TOWN Baltimore		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 5912 Meadowood Road			
14. FATHER'S NAME FIRST MIDDLE LAST Thomas C. McGuire				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Florence Mills							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) No		16b. SOCIAL SECURITY NO. 214 40 4696		17. INFORMANT ADDRESS Ralph E. Baylor, Arlington, Va.							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute myocardial infarction</u> 4100 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last: (b) <u>Arteriosclerotic cardiovascular disease</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>Essential hypertension</u>										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>Sudden</u> <u>Sev. years</u> <u>Sev. years</u>	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <u>Hypothyroidism - Sev. years.</u>											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)							
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE							
22a. I certify that (I) (this hospital) attended the deceased from <u>11-26</u> , 19 <u>60</u> , to <u>2-16</u> , 19 <u>82</u> , that (I) (we) last saw the deceased alive on <u>2-14</u> , 19 <u>82</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE <u>Alfred G. Ossman, M.D.</u>						DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 2/17/82			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Dr. Alfred G. Ossman, M.D.						22e. ADDRESS 1101 St. Paul Street, Balto., Md.					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 2/19/82		23c. NAME OF CEMETERY OR CREMATORY Loudon Park		23d. LOCATION CITY OR TOWN COUNTY STATE Balto., Md.					
24. FUNERAL DIRECTOR NAME Henry W. Jenkins & Sons Co. ADDRESS 4905 York Road Balto., Md. 21212						25a. DATE REC'D. BY REGISTRAR FEB 18 1982					

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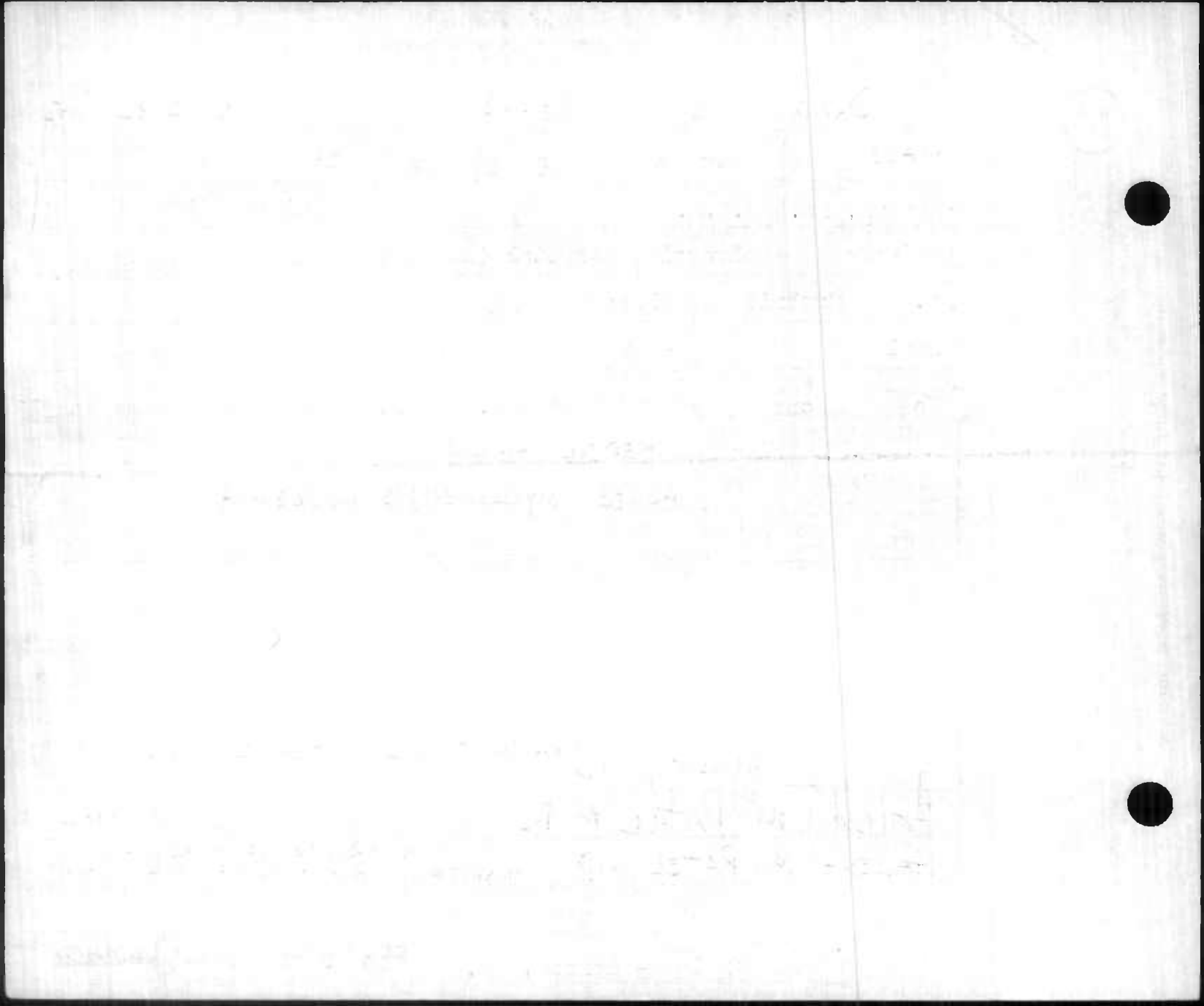
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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 of 4 must be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										REG. NO. 8203541					
1. DECEASED NAME (TYPE OR PRINT) DAVID E. BEAHR										2a. DATE OF DEATH MONTH DAY YEAR 02 12 82		2b. HOUR 115A			
3. SEX MALE		4. RACE WHITE		5. DATE OF BIRTH MONTH DAY YEAR 10 07 58		6. AGE (IN YEARS LAST BIRTHDAY) 23		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.					
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Johnstown, Pa.		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City MD.									
10. CITY OR TOWN OF DEATH Baltimore		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) University Hospital (BCRC)						12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Labor		12b. KIND OF BUSINESS OR INDUSTRY Commonwealth Stone Co.					
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) Pa. Cambria										13b. CITY OR TOWN Hallsopple		13c. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13d. STREET ADDRESS Box # 30	
14. FATHER'S NAME FIRST MIDDLE LAST Earl Beahr				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Shirley Marie Lambert											
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. None		17. INFORMANT ADDRESS Mrs. Pamela Beahr (wife) Same as #13											
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 2050 SEPTIC SHOCK DUE TO, OR AS A CONSEQUENCE OF (b) ACUTE MYELOGENOUS LEUKEMIA Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last } DUE TO, OR AS A CONSEQUENCE OF (c)										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)															
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>							
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)											
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE											
22a. I certify that (I) (this hospital) attended the deceased from Jan 29th, 1982 to FEB. 12, 1982 , that (I) (we) lost saw the deceased alive on Feb. 12th, 1982 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.															
22b. SIGNATURE Halesh M. Patel M.D.		DEGREE		ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>				22c. DATE SIGNED 2/12/82							
22d. PHYSICIAN'S NAME (TYPE OR PRINT) HALESH M. PATEL, M.D.		22e. ADDRESS UNIVERSITY OF MARYLAND HOSPITAL, BALTIMORE, MARYLAND													
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 2/14/82		23c. NAME OF CEMETERY OR CREMATORY Custer Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE Paint Township Pa.									
24. FUNERAL DIRECTOR NAME E. Barnes				ADDRESS Fleming Funeral Service - Benson, Md.				25a. DATE REC'D. BY REGISTRAR FEB 16 1982							



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified by phone.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 2 0 3 5 4 2

REG. NO.

1. FOR STATE REGISTRAR		2a. DATE OF DEATH		2b. HOUR	
1. DECEASED NAME (TYPE OR PRINT)		2a. DATE OF DEATH		2b. HOUR	
ROSE BEAR		2-24-82		1:55A	
3. SEX	4. RACE	5. DATE OF BIRTH	6. AGE	7. IF UNDER 1 YEAR	
FEMALE	WHITE	08 20 1982	83 YRS	MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			
MARYLAND	USA	9. BALTIMORE CITY OR COUNTY OF DEATH			
BALTIMORE	SINAI HOSPITAL	BALTIMORE CITY MD.			
10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)	12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY	
BALTIMORE	SINAI HOSPITAL	HOUSEWIFE		AT HOME	
13a. STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS?	13e. STREET ADDRESS	
MARYLAND	BALTIMORE	BALTIMORE	YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	APT. 612	
14. FATHER'S NAME	15. MOTHER'S MAIDEN NAME	16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)			
PHILIP W. GUNDERSHEIMER	CARRIE BERGMAN	NO			
16b. SOCIAL SECURITY NO.	17. INFORMANT	18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)			
214-01-9676B	SUN LIFE BLDG. 20 S. CHARLES ST. 21201	SEPSIS - PNEUMONIA			
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY?	
				YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
		HOUR A.M. MONTH DAY YEAR			
		P.M. 19			
21d. INJURY OCCURRED		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION	
WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>				CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from		22b. SIGNATURE		22c. DATE SIGNED	
02/24/82		TERESA TIEFFERT MD.		2/24/82	
22d. PHYSICIAN'S NAME (TYPE OR PRINT)		22e. ADDRESS		23a. NAME OF CEMETERY OR CREMATORY	
TERESA TIEFFERT		3405 Greenway, Apt 3G, Balto. Md 21218		HEBREW FRIENDSHIP	
23b. DATE		23c. LOCATION		23d. COUNTY	
FEB. 24, 1982		BALTIMORE		MARYLAND	
24. FUNERAL DIRECTOR		25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR	
SOL LEVINSON & BROS., INC.		MAR 4 1982		James J. Sullivan	
6010 REISTERSTOWN RD. BALTO., MD 21215					

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page should be detached for use as the burial/transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

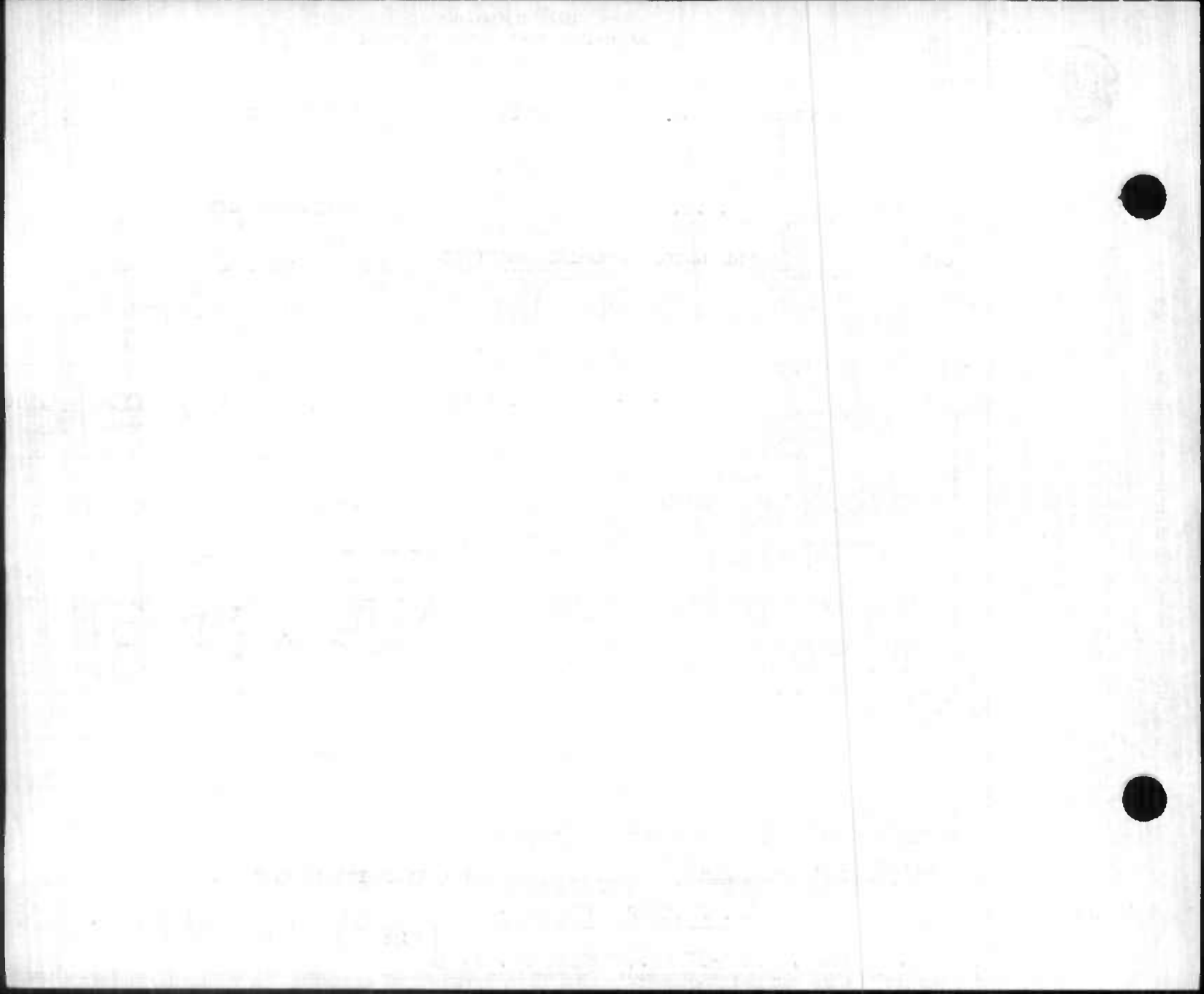
IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1. FOR
STATE
REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST MARGARET J. BEATTIE			2a. DATE OF DEATH MONTH DAY YEAR 2/22/82		2b. HOUR 12 ⁰¹ M
3. SEX FEMALE	4. RACE WHITE	5. DATE OF BIRTH MONTH DAY YEAR JUNE 23, 1921	6. AGE (IN YEARS LAST BIRTHDAY) 60 YRS.	7. IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MARYLAND	7b. CITIZEN OF WHAT COUNTRY? U.S.A.	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE CITY MD.		
10. CITY OR TOWN OF DEATH BALTIMORE CITY	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) THE UNION MEMORIAL HOSPITAL		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) HOMEMAKER	12b. KIND OF BUSINESS OR INDUSTRY	
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE MARYLAND 13b. COUNTY HARFORD 13c. CITY OR TOWN WHITEFORD			13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET ADDRESS 1406 CHESTNUT STREET	
14. FATHER'S NAME FIRST MIDDLE LAST SIMON BEATTIE		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST SUSIE HUGHES			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO	16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 219-07-4944	17. INFORMANT ADDRESS C. KENNETH BEATTIE, WHITEFORD, MARYLAND 21160			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Profound Intracranial Hemorrhage</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>Hepatic Failure</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>Histiocytic Lymphoma</u> PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
19a. DATE OF OPERATION —	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED —		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from <u>2/13</u> 19 <u>82</u> , to <u>2/22</u> 19 <u>82</u> , that (I) (we) last saw the deceased alive on <u>2/21</u> 19 <u>82</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did not) view the body after death.					
22b. SIGNATURE <u>L. Matthews MD</u>		DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		22c. DATE SIGNED 2/22/82	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Laurie J Matthews MD		22e. ADDRESS 201 UNIVERSITY PARKWAY			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL	23b. DATE FEB. 25, 1982	23c. NAME OF CEMETERY OR CREMATORY SLATE RIDGE	23d. LOCATION CITY OR TOWN COUNTY STATE DELTA, YORK COUNTY, PA.		
24. FUNERAL DIRECTOR NAME JOHN H. HARKINS, 600 MAIN ST.,		24b. ADDRESS DELTA, PA. 17314			

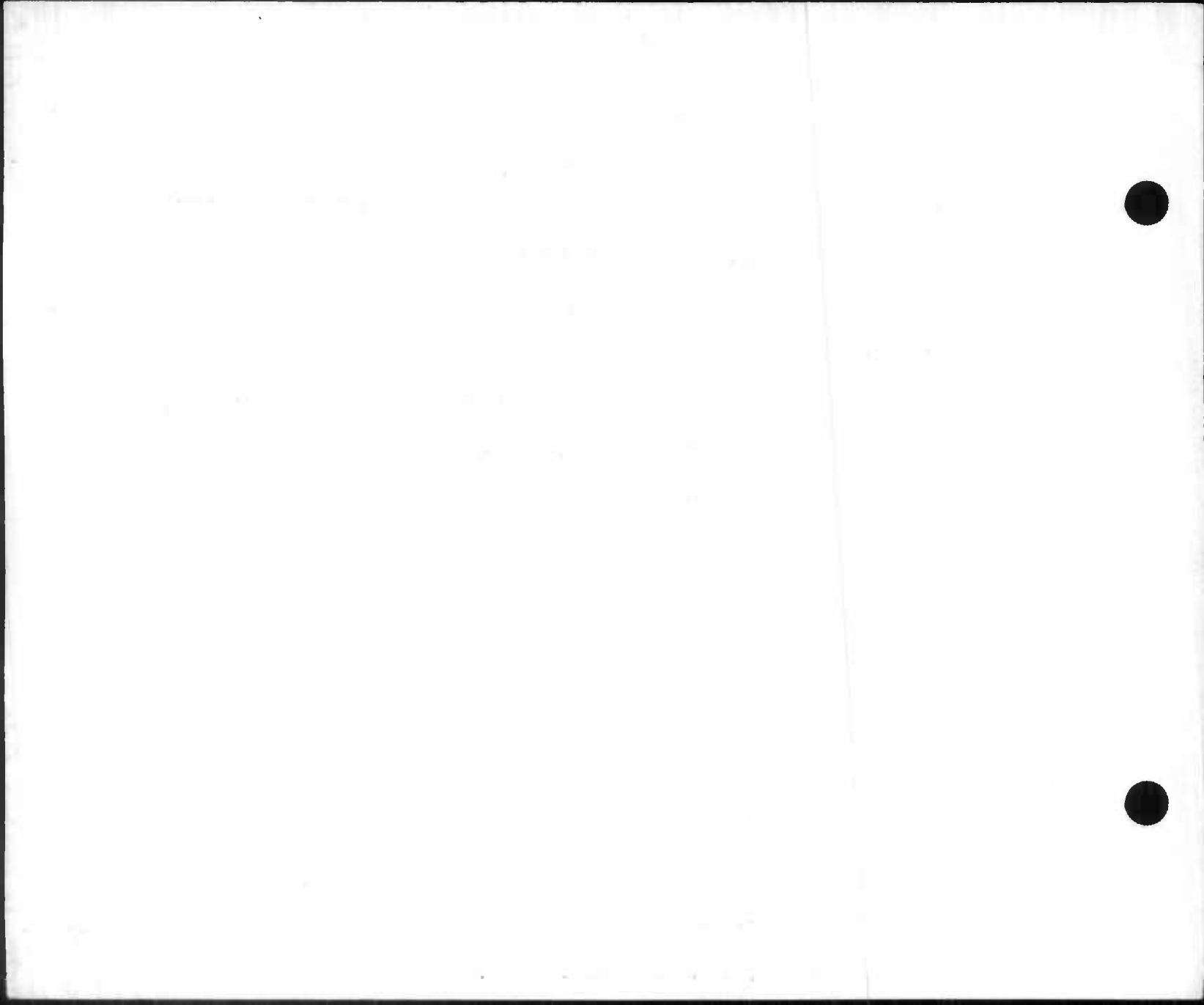


TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified in advance.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										REG. NO.	
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST CHRISTIANA BETTY BEAVER					2a. DATE OF DEATH MONTH DAY YEAR 2 4 82			2b. HOUR 2:18 PM			
3. SEX F		4. RACE W		5. DATE OF BIRTH MONTH DAY YEAR 10 11 81		6. AGE (IN YEARS LAST BIRTHDAY) 0 YRS 3 21		7a. IF UNDER 1 YEAR MONTHS DAYS 3 21		7b. IF UNDER 24 HRS HOURS MIN.	
7c. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MD		7d. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE CITY MD.					
10. CITY OR TOWN OF DEATH BALTIMORE		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) ST. AGNES HOSPITAL				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) N/A		12b. KIND OF BUSINESS OR INDUSTRY N/A			
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE MD		13b. CITY OR TOWN BALTIMORE		13c. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13d. STREET ADDRESS 517 LUCIA AV MD 21229					
14. FATHER'S NAME FIRST MIDDLE LAST MARTIN BEAVER		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST CYNTHIA SHAFFER									
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) N/A		16b. SOCIAL SECURITY NO. NONE		17. INFORMANT ADDRESS MARTIN BEAVER 517 LUCIA AVENUE, 21229							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>CARDIO PULMONARY ARREST</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>POSSIBLE EXTENSIVE AND SEVERE</u> DUE TO, OR AS A CONSEQUENCE OF <u>VIRAL INFECTION</u>										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 3 days	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (c):											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE							
22a. I certify that (I) (this hospital) attended the deceased from <u>2/2/82</u> 19 <u>82</u> to <u>2/4</u> 19 <u>82</u> , that (I) (we) last saw the deceased alive on <u>2/4</u> 19 <u>82</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE <u>S Chittchang</u>				DEGREE MD				ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 2/4/82	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) S CHITTCHAN 6 MD				22e. ADDRESS 6217 FREDERICK RD MD 21228							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL		23b. DATE 02-06-82		23c. NAME OF CEMETERY OR CREMATORY LOUDON PARK		23d. LOCATION CITY OR TOWN COUNTY STATE BALTIMORE CITY MARYLAND		25a. DATE REC'D. BY REGISTRAR FEB 5 1982			
24. FUNERAL DIRECTOR NAME HUBBARD FUNERAL HOME, INC.		ADDRESS 4107 WILKENS AVE.		25b. DATE REC'D. BY REGISTRAR FEB 5 1982		25c. REGISTRAR'S SIGNATURE <u>Charles J. [Signature]</u>					

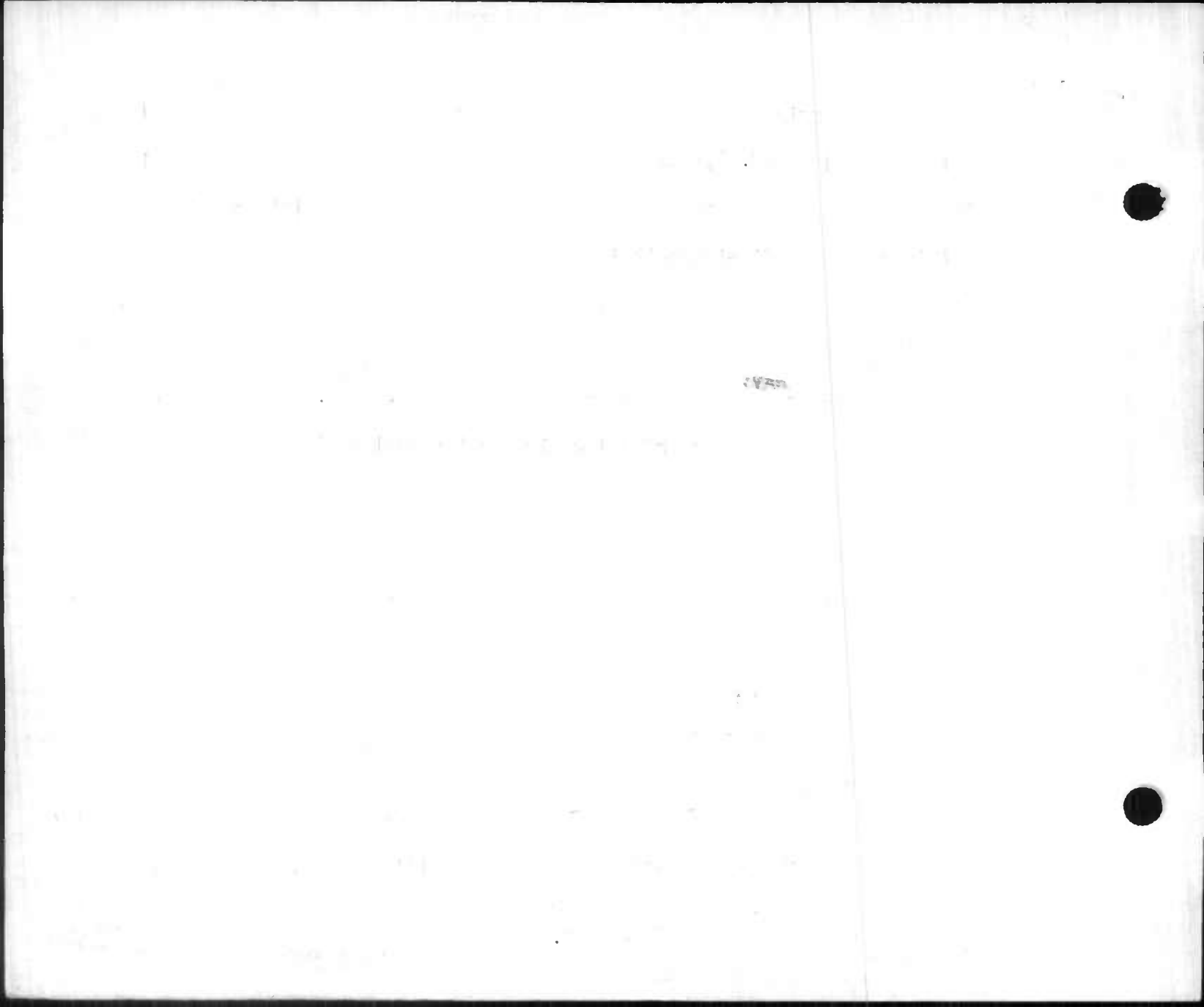


TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED. WITHIN 24 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

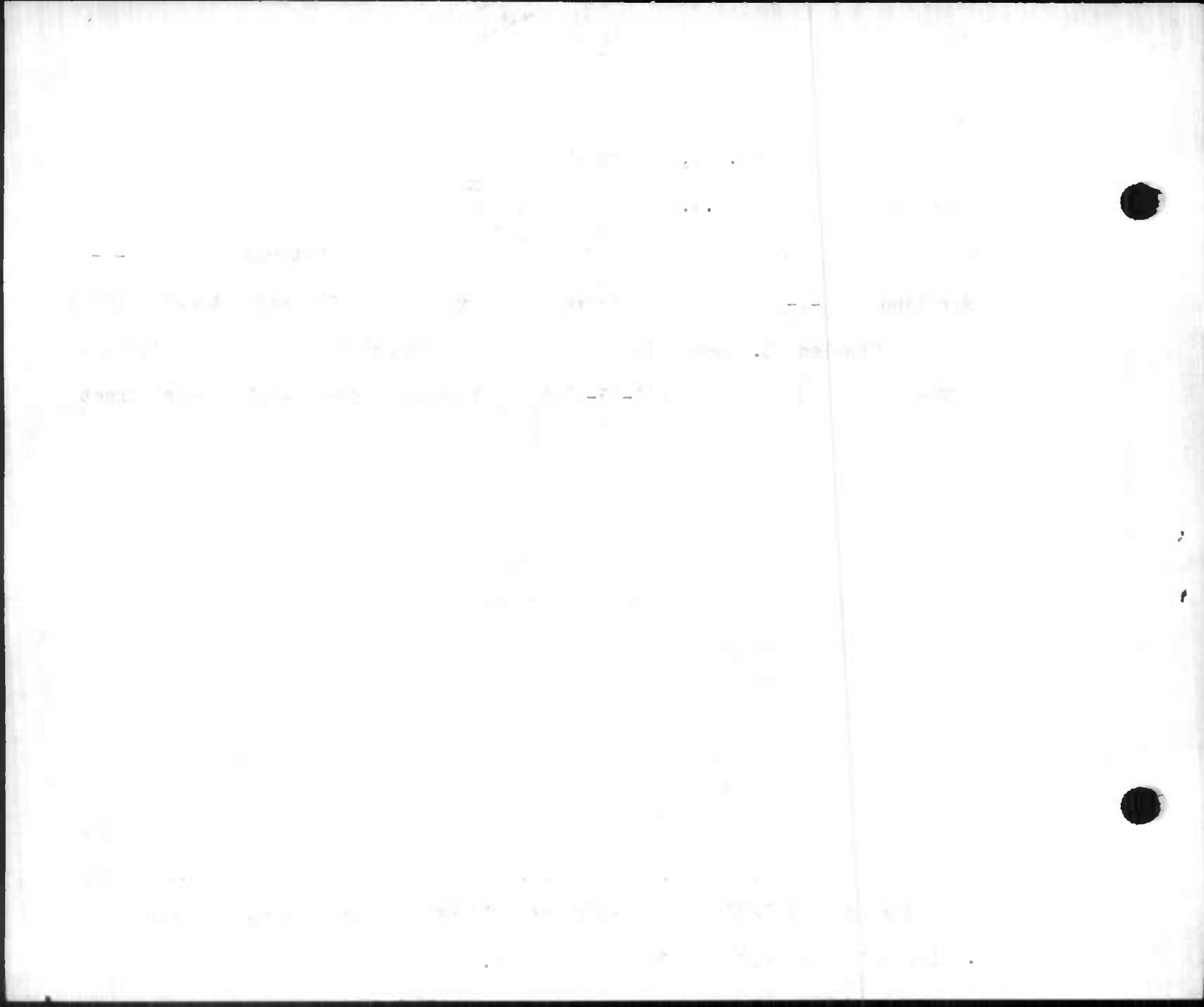
1. FOR STATE REGISTRAR		2. DATE KNOWN OF DEATH		3. MONTH		4. DAY		5. YEAR		6. HOUR	
1. DECEASED NAME (TYPE OR PRINT)		FIRST		MIDDLE		LAST		2. DATE KNOWN OF DEATH		3. MONTH	
Morris		Beber						2. DATE KNOWN OF DEATH		3. MONTH	
4. RACE		5. DATE OF BIRTH		6. AGE (IN YEARS)		IF UNDER 1 YR.		IF UNDER 24 HRS.		7. HOUR	
Male		White		AUG. 27, 1913		68 YRS.				2. DATE KNOWN OF DEATH	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED		NEVER MARRIED		9. BALTIMORE CITY OR COUNTY OF DEATH		10. HOUR	
WISCONSIN		USA		XX				Baltimore City,		2:43	
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY					
Baltimore		Sinai Hospital		ACCOUNTANT		ACCOUNTING					
13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE (CITY LIMITS?)		13e. STREET ADDRESS		14. FATHER'S NAME	
MARYLAND				BALTIMORE		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		6606 EBERLE DR., APT. 202		PHILIP	
14. FATHER'S NAME		15. MOTHER'S MAIDEN NAME		16a. WAS DECEASED EVER IN U.S. ARMED FORCES?		16b. SOCIAL SECURITY NO.		17. INFORMANT		18. CAUSE OF DEATH	
PHILIP		SARAH LEAH DASHEF		YES		105-12-6345		MRS. GOLDIE BEBER		PART 1 DEATH WAS CAUSED BY:	
								EBERLE DR., APT. 202		IMMEDIATE CAUSE (a) Arteriosclerotic cardiovascular disease	
								BALTO., MD 21215		(b) _____	
										(c) _____	
										PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).	
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?		20. AUTOPSY?							
				YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)							
		P.M. 19									
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION							
				CITY OR TOWN		COUNTY		STATE			
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from		Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>		22b. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from		Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>					
ACTUAL SIGNATURE		TITLE (SPECIFY)		DATE SIGNED							
Thomas D. Smith		M.D. Deputy Chief		2/2/82							
EXAMINER'S NAME (TYPE OR PRINT)		ADDRESS		23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION	
Thomas D. Smith, M.D.		III Penn St. Balto. Md.		BURIAL		FEB. 2, 1982		BETH YEHODA		BALTIMORE	
24. FUNERAL DIRECTOR		25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE							
SOL LEVINSON & BROS., INC.		FEB 11 1982		James J. Smith							
6010 REISTERSTOWN RD. BALTO., MD 21215											



TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE FORMS 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED. WITHIN 10 DAYS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH										REG. NO. 3 2 0 3 5 4 6	
1- FOR STATE REGISTRAR											
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Elmer E Benjamin										2a. DATE KNOWN OF DEATH ESTIMATED <input checked="" type="checkbox"/> MONTH DAY YEAR 2 1 1982	
3. SEX male		4. RACE white		5. DATE OF BIRTH MONTH DAY YEAR Feb. 16, 1909		6. AGE (IN YEARS LAST BIRTHDAY) MONTHS DAYS 72 YRS.		IF UNDER 1 YR. IF UNDER 24 HRS.		2c. DATE PRONOUNCED DEAD MONTH DAY YEAR 2 1 1982	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland				7b. CITIZEN OF WHAT COUNTRY? U.S.A.				8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City	
10. CITY OR TOWN OF DEATH Baltimore				11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 3534 Poole Street				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Retired		12b. KIND OF BUSINESS OR INDUSTRY --	
USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)											
13a. STATE Maryland		13b. COUNTY		13c. CITY OR TOWN Baltimore		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 3534 Poole Street (21211)			
14. FATHER'S NAME FIRST MIDDLE LAST Charles L. Benjamin						15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Carrvilla Williams					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) Yes				16b. SOCIAL SECURITY NO. 213-03-4145		17. INFORMANT ADDRESS Charles Benjamin - 3528 Poole Street					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Arteriosclerotic cardiovascular disease</u> 4292 } CONDITIONS, IF ANY, WHICH GAVE RISE TO IMMEDIATE CAUSE (a) STATING THE UNDERLYING CAUSE LAST. (b) _____ (c) _____ DUE TO, OR AS A CONSEQUENCE OF DUE TO, OR AS A CONSEQUENCE OF										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I											
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?						20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION CITY OR TOWN COUNTY STATE					
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural cause <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> .											
ACTUAL SIGNATURE <u>Margarita A. Korell</u>						TITLE (SPECIFY) M.D. Assistant			DATE SIGNED 2/1/82		
EXAMINER'S NAME (TYPE OR PRINT) Margarita A. Korell, M.D.						ADDRESS 111 Penn Street, Balto., MD 21201					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial				23b. DATE 2/3/82		23c. NAME OF CEMETERY OR CREMATORY Lorraine Park Cem				23d. LOCATION CITY OR TOWN COUNTY STATE Baltimore, Maryland	
24. FUNERAL DIRECTOR NAME A. Alan Seitz Funeral Home						ADDRESS 3818 Roland Ave.			25. DATE REC'D. BY REGISTRAR FEB 3 1982		



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.1- FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 2 0 3 5 4 7

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) WESLEY W. BENN			2a. DATE OF DEATH MONTH DAY YEAR 02-09-82			2b. HOUR 4:52 P.M.			
3. SEX M		4. RACE B		5. DATE OF BIRTH MONTH DAY YEAR 09 02 18		6. AGE (IN YEARS LAST BIRTHDAY) 63 YRS		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Virginia		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City MD.			
10. CITY OR TOWN OF DEATH Baltimore		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) SINAI HOSPITAL				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY	
13a. STATE MD		13b. COUNTY Baltimore		13c. CITY OR TOWN Baltimore		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 3530 Reisterstown Rd.	
14. FATHER'S NAME FIRST MIDDLE LAST Mack Benn			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Mammie Scott						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) N/A		17. INFORMANT Mabel Benn		ADDRESS 3530 Reisterstown Rd.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: 5724 End stage hepato renal failure IMMEDIATE CAUSE (a) 5724 DUE TO, OR AS A CONSEQUENCE OF (b) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO, OR AS A CONSEQUENCE OF (c) _____								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from Jan. 12 19 82 , to Feb. 9 19 82 , that (I) (we) last saw the deceased alive on Feb 9 19 82 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE TERESA TIFERT M.D. (PGY-I)		DEGREE		22c. DATE SIGNED 2/9/82					
22d. PHYSICIAN'S NAME (TYPE OR PRINT) TERESA TIFERT		22e. ADDRESS 3405 Greenway, Apt 36, Balto., Md. 21218							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 2/13/82		23c. NAME OF CEMETERY OR CREMATORY Carver Mem. Cem.		23d. LOCATION CITY OR TOWN COUNTY STATE Suffolk VA			
24. FUNERAL DIRECTOR NAME ADDRESS Wm. C. March F/H, Inc. 1101 E. North Avenue				25a. DATE REC'D. BY REGISTRAR FEB 11 1982					
				25b. REGISTRAR'S SIGNATURE <i>James J. Nathan</i>					

M. D. M.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 1 and 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

DMHM-16 30M 2/80
(VRA 15, 4)

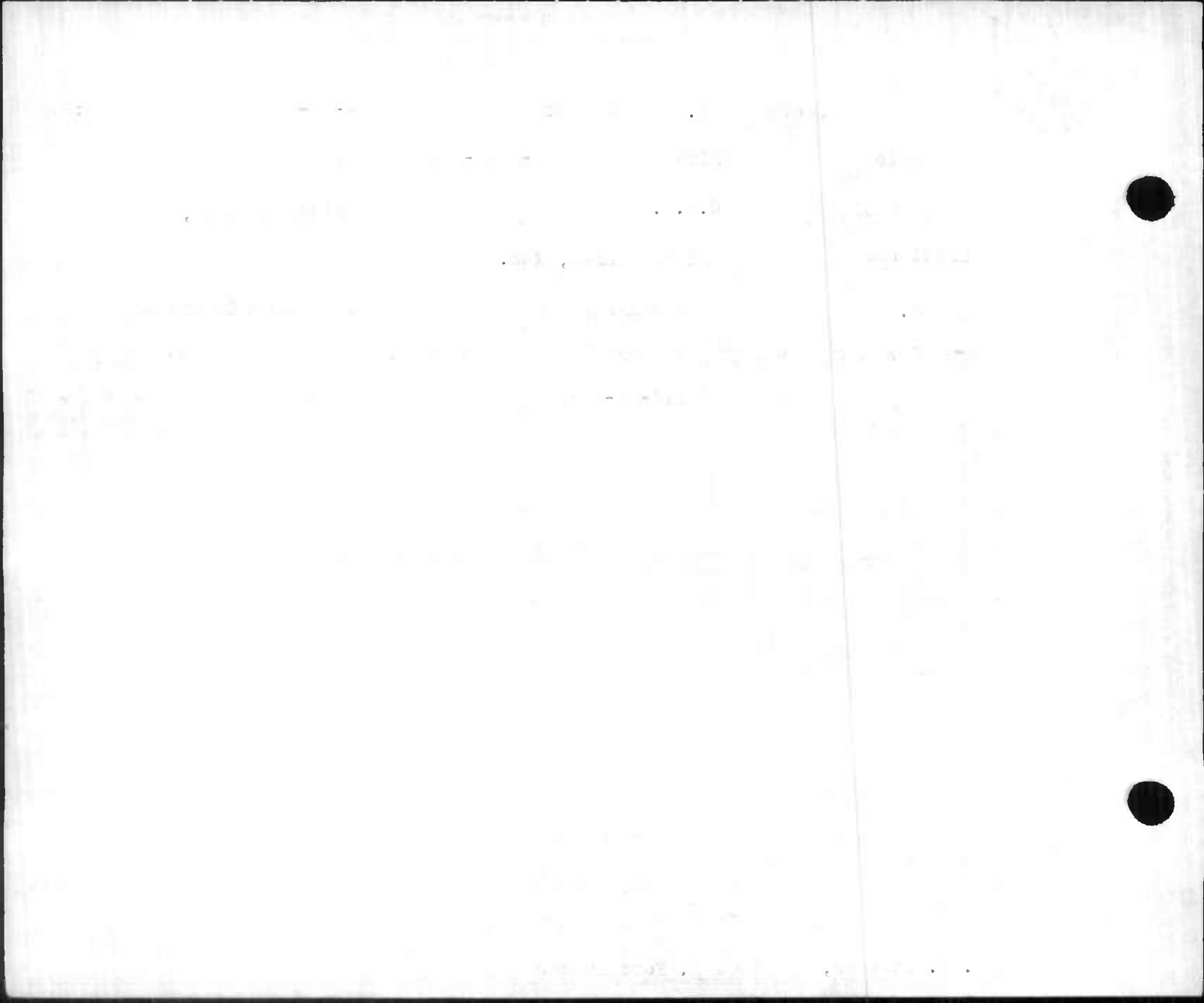
STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										8 2 0 3 5 4 8 REG. NO.			
1. DECEASED NAME (TYPE OR PRINT) George R. Bennett						2a. DATE OF DEATH MONTH DAY YEAR 2-01-82				2b. HOUR 10:05p _M			
3. SEX Male		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR 8 - 22 - 06		6. AGE (IN YEARS LAST BIRTHDAY) 75		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City, MD							
10. CITY OR TOWN OF DEATH Baltimore		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Midtown Home, Inc.				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Sanitation Worker		12b. KIND OF BUSINESS OR INDUSTRY Baltimore City					
13a. STATE Md.		13b. COUNTY		13c. CITY OR TOWN Baltimore		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 1321 Cooksie Street					
14. FATHER'S NAME FIRST MIDDLE LAST GEORGE R. BENNETT				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST MARGARET FALGLE									
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 217-09-6267		17. INFORMANT Helen A. Bennett				ADDRESS 1321 Cooksie Street					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1: DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) - <u>Cordiospasm</u> 5860 DUE TO, OR AS A CONSEQUENCE OF (b) - <u>Arteriosclerotic Cordovascular disease</u> DUE TO, OR AS A CONSEQUENCE OF (c) - <u>Heart Failure</u>													
PART 2: OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)													
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE							
22a. I certify that (I) (this hospital) attended the deceased from <u>6/1/81</u> 19 <u>81</u> to <u>2/1/82</u> 19 <u>82</u> , that (I) (we) last saw the deceased alive on <u>1-28-</u> 19 <u>82</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.													
22b. SIGNATURE R. Reid				DEGREE M.D.				ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 2-3-82			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) RUBEN REIDER M.D.				22e. ADDRESS 1406 Green Highway South - Suite 172 P.O. Box 2106									
23a. BURIAL, CREMATION, REMOVAL (TYPE)		23b. DATE 2/4/82		23c. NAME OF CEMETERY OR CREMATORY Midtown Home, Inc.		23d. LOCATION CITY OR TOWN COUNTY STATE							
24. FUNERAL DIRECTOR NAME C. L. Stevens				ADDRESS 1501 E. Fort Avenue				25a. FEB 4 1982 25b. REGISTRAR'S SIGNATURE					

MEDICAL CERTIFICATION

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2401 BP



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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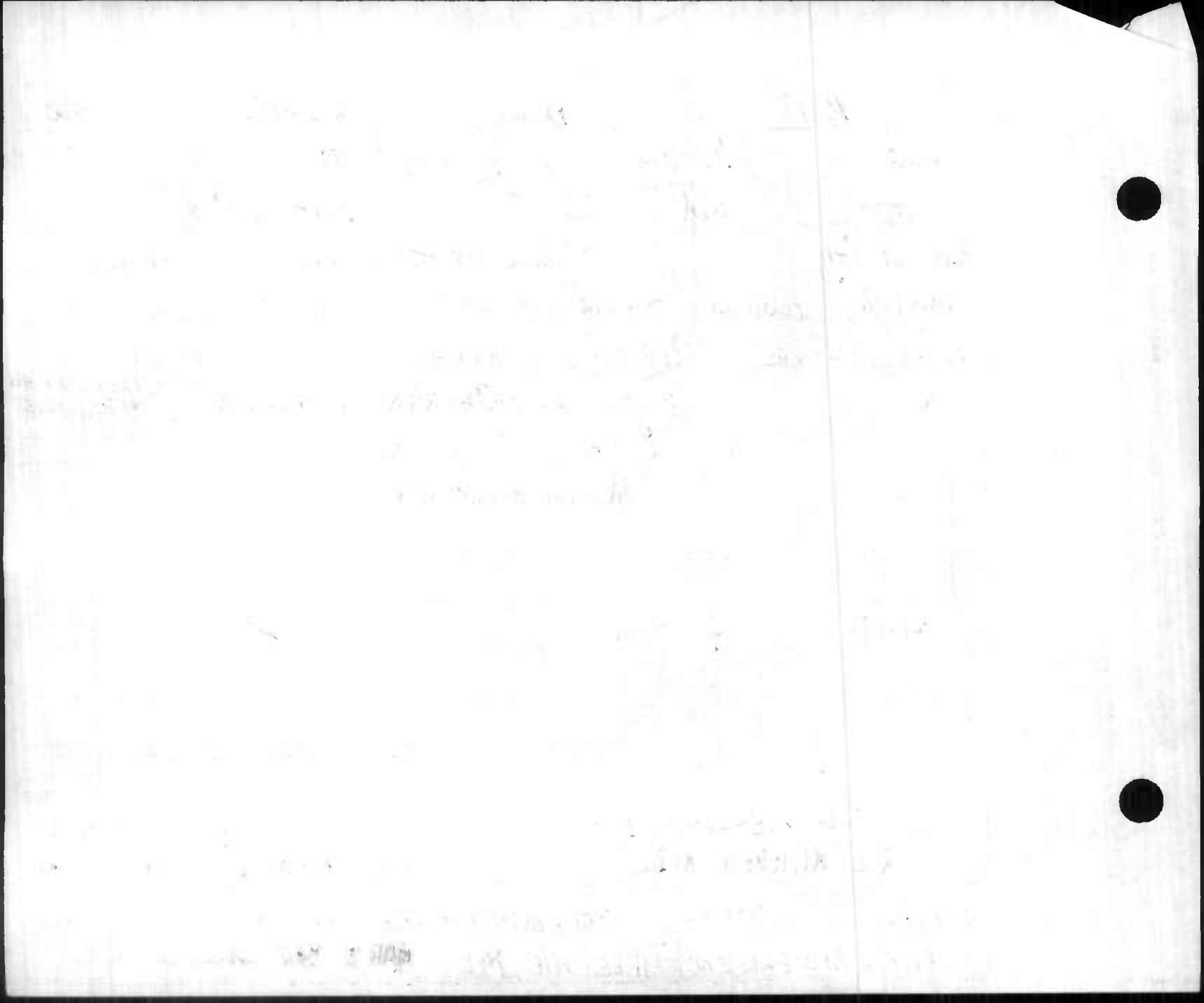
IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 2 0 3 5 4 9

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Paul E Benson		2a. DATE OF DEATH MONTH DAY YEAR 2/26/82		2b. HOUR MIN. 1530	
3. SEX male	4. RACE Caucasian	5. DATE OF BIRTH MONTH DAY YEAR 1 5 1900		6. AGE (IN YEARS LAST BIRTHDAY) 82 YRS. MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MD	7b. CITIZEN OF WHAT COUNTRY? USA	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City MD.	
10. CITY OR TOWN OF DEATH Baltimore City	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Sinai Hospital		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) INSURANCE		12b. KIND OF BUSINESS OR INDUSTRY RETIRED
13a. USUAL RESIDENCE (IF NOT IN HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Maryland 13b. COUNTY Baltimore 13c. CITY OR TOWN Baltimore		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 5219 Florence Ave.	
14. FATHER'S NAME FIRST MIDDLE LAST SAMUEL THOMAS BENSON		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST SARAH C. BROWN		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO	
16b. SOCIAL SECURITY NO. 215-03-2234A		17. INFORMANT ADDRESS 5219 FLORENCE AVE BALTO. 21215		18. CAUSE OF DEATH (Enter only one cause per line last (b), and last (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Respiratory Compromise 5789 DUE TO, OR AS A CONSEQUENCE OF (b) Massive Hemorrhage Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last DUE TO, OR AS A CONSEQUENCE OF (c)	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (c)					
19a. DATE OF OPERATION 2/4/82		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED GI Bleed.		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			
21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1, OR PART 2)			
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from 2/3 19 82 to 2/26 19 82 , that (I) (we) lost saw the deceased alive on 2/26 19 82 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) did not view the body after death.					
22b. SIGNATURE R.L. Mitchell M.D.		DEGREE		22c. DATE SIGNED 2/26/82	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) R.L. Mitchell M.D.		22e. ADDRESS Sinai Hospital of Baltimore Md.			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL		23b. DATE 3-1-82		23c. NAME OF CEMETERY OR CREMATORY WOODLAWN CEMETERY	
23d. LOCATION CITY OR TOWN COUNTY STATE WOODLAWN BALTO. MD.		24. FUNERAL DIRECTOR NAME ADDRESS FRANK H. NEWELL INC Pikesville, MD			
25a. DATE REC'D. BY REGISTRAR MAR 2 1982		25b. REGISTRAR'S SIGNATURE Thane Jan			



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1. FOR
STATE
REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 2 0 3 5 5 0

REG. NO.

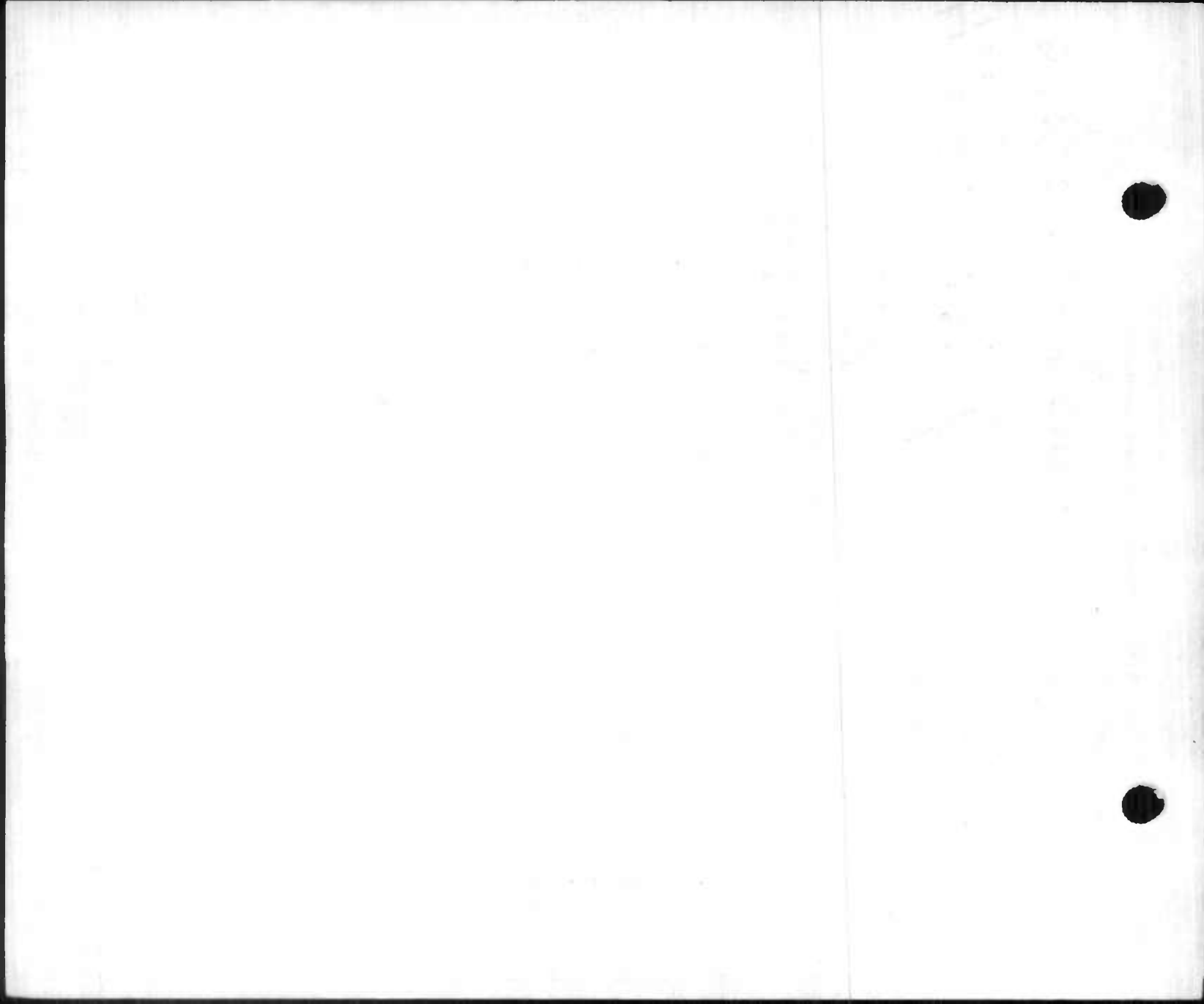
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST PATRICIA ANN BETZ			2a. DATE OF DEATH MONTH DAY YEAR 02 06 82		2b. HOUR 1148 P.M.	
3. SEX Female		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR June 30, 1937		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Florida		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		6. AGE (IN YEARS LAST BIRTHDAY) YRS. MONTHS DAYS 44		
10. CITY OR TOWN OF DEATH BALTIMORE		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) UNION MEMORIAL HOSPITAL		9. BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE CITY MD.		
13a. STATE Maryland		13b. COUNTY Baltimore		13c. CITY OR TOWN Baltimore		
14. FATHER'S NAME FIRST MIDDLE LAST Charles Bond		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Lucille Dickinson		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Housewife		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 219-34-0518		17. INFORMANT ADDRESS Charles Bond 5003 Edgar Terrace Balto. Md.		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) PULMONARY EMBOLUS 7078 DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.						
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a): (R) SACRAL DECUBITUS ULCER, MANIC-DEPRESSIVE PSYCHOSIS						
19a. DATE OF OPERATION 02, 04, 82		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED (R) SACRAL ULCERATION		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)		
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE		
22a. I certify that (I) (this hospital) attended the deceased from 01/23 , 19 82 to 02/06 , 19 82 , that (I) (we) last saw the deceased alive on 02/06 , 19 82 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.						
22b. SIGNATURE Guillermo Tejada		DEGREE MD ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		22c. DATE SIGNED 02/07/82		
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Entombment		23b. DATE Feb. 9, 1982		23c. NAME OF CEMETERY OR CREMATORY Dulaney Valley Maus.		
24. FUNERAL DIRECTOR Leonard J. Ruck, Inc. Baltimore, Maryland		23d. LOCATION CITY OR TOWN COUNTY STATE Cockeysville Maryland		25a. DATE REC'D. BY REGISTRAR FEB 8 1982		
				25b. REGISTRAR'S SIGNATURE [Signature]		

100

101

102





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 must be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 2 0 3 5 5 2

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST HAZEL L BLAKE			2a. DATE OF DEATH MONTH DAY YEAR 2 19 82		2b. HOUR 12:20PM	
3 SEX Female		4 RACE White		5. DATE OF BIRTH MONTH DAY YEAR January 30, 1910		
6 AGE (IN YEARS LAST BIRTHDAY) 72		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.		IF UNDER 24 HRS.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		
9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City MD						
10. CITY OR TOWN OF DEATH Baltimore		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) St. Agnes Hospital		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Homemaker		
12b. KIND OF BUSINESS OR INDUSTRY		13a. STREET ADDRESS 5205 W. North Avenue		13b. CITY OR TOWN Baltimore		
14. FATHER'S NAME FIRST MIDDLE LAST Edwin Herman Mehner		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Laura Loretta Renehan				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. 214-05-3230		17. INFORMANT ADDRESS Mrs. Geraldine Munchel 3853 Norrisville Road		

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiac failure DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) Respiratory failure DUE TO, OR AS A CONSEQUENCE OF (c) C.V.A.				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1. (a) CA Rectum. CA Breast.					
19a. DATE OF OPERATION 2/6/82		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED CA Rectum		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH? (IF EITHER, NOTIFY MEDICAL EXAMINER) <input checked="" type="checkbox"/>			
21b. TIME OF INJURY HOUR AM MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from 2/4 19 82 to 2/19 19 82 that (I) (we) lost saw the deceased alive on 2/19 19 82 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE Dr. Nanavati				22c. DATE SIGNED 2/19/82	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) DR. NANAVATI				22e. ADDRESS St. Agnes Hospital	
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 2-23-1982		23c. NAME OF CEMETERY OR CREMATORY Lorraine Park	
23d. LOCATION CITY OR TOWN COUNTY STATE Baltimore Maryland		24. FUNERAL DIRECTOR Ruck Towson Funeral Home, Inc. ADDRESS Towson, Maryland			
25a. DATE REC'D. BY REGISTRAR FEB 22 1982		25b. REGISTRAR'S SIGNATURE James J. Nathan			

1961-1962

1961-1962

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be returned by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										REG. NO. 8 2 0 3 5 5 3			
1. DECEASED NAME (TYPE OR PRINT) Mable G. Bland										2a. DATE OF DEATH MONTH DAY YEAR 2 1 82		2b. HOUR 9:15 P M	
3 SEX Female		4 RACE Black		5. DATE OF BIRTH MONTH DAY YEAR 3 1 95		6 AGE (IN YEARS LAST BIRTHDAY) 86 YRS.		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Virginia		7b. CITIZEN OF WHAT COUNTRY? U.S.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH Baltimore City MD.							
10 CITY OR TOWN OF DEATH Baltimore		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Lutheran Hospital						12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY			
13a. STATE MD		13b. COUNTY MD		13c. CITY OR TOWN Baltimore		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 1619 Riggs Ave.					
14. FATHER'S NAME FIRST MIDDLE LAST				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Anna Page				16. INFORMANT ADDRESS Larry Bland New Jersey					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)				16b. SOCIAL SECURITY NO. 158-16-5690									
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Cardiopulmonary Arrest DUE TO, OR AS A CONSEQUENCE OF (b) Ischemic Encephalopathy DUE TO, OR AS A CONSEQUENCE OF (c) Acute Pulmonary Embolism + Full Arrest													
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) Upper Gastrointestinal Bleeding on Heparin													
19a. DATE OF OPERATION 12/28/81		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED Right Hip Fracture				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)									
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE									
22a. I certify that (I) this hospital attended the deceased from 12/27 19 81 to 2/1 19 82 , that (I) (we) last saw the deceased alive on 2/1 19 82 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.													
22b. SIGNATURE Darrell M. Gray MD DEGREE MD ATTENDING PHYSICIAN <input checked="" type="checkbox"/> DIRECTOR <input type="checkbox"/> BY MEDICAL EXAMINER <input type="checkbox"/>						22c. DATE SIGNED 2/1/82							
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Darrell M. Gray, M.D.						22e. ADDRESS Lutheran Hospital							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Removal		23b. DATE 2/4/82		23c. NAME OF CEMETERY OR CREMATORY Hackensack		23d. LOCATION CITY OR TOWN COUNTY STATE Hackensack N. Jersey							
24. FUNERAL DIRECTOR NAME E.C. Phillips ADDRESS 1721 MONROE						25a. DATE REC'D. BY REGISTRAR FEB 4 1982		25b. REGISTRAR'S SIGNATURE Thomas J. Phillips					

RECEIVED FROM THE
LIBRARY OF THE
MUSEUM OF NATURAL HISTORY

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, it should be filed in the office of the funeral director. Page 3 should be detached for use as the burial-transit permit. Then page 4 should be filed in the office of the funeral director. Page 4 may be retained by the funeral director. Page 4 should be filed in the office of the funeral director. Page 4 may be retained by the funeral director.

IMPORTANT: If item 21 is marked or item 18 shows only injury, or other traumatic event, the medical examiner must be notified.

1. FOR
STATE
REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 2 0 3 5 5 4

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) Ignatius M. Blaszak			2a. DATE OF DEATH MONTH DAY YEAR Feb 04 1982		2b. HOUR MIN. 2:50P	
3. SEX Male		4. RACE Caucasian		5. DATE OF BIRTH MONTH DAY YEAR April 1, 1917		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Balto., Md.		7b. CITIZEN OF WHAT COUNTRY? U. S. A.		6. AGE (IN YEARS (LAST BIRTHDAY)) YRS. MONTHS DAYS 64		
10. CITY OR TOWN OF DEATH Baltimore		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF IN HOSPITAL, GIVE FACILITY AND STREET ADDRESS) Johns Hopkins Hospital		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City MD		
12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Machine Operator		12b. KIND OF BUSINESS OR INDUSTRY Can Mfg.				
13a. STATE Maryland		13b. COUNTY ---		13c. CITY OR TOWN Baltimore		
14. FATHER'S NAME FIRST MIDDLE LAST Joseph Blaszak		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Josephine Kowalewski		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) Yes		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) W. W. II 217-01-7837		17. INFORMANT ADDRESS Margaret M. Blaszak- 742 N. Linwood Ave.		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiopulmonary arrest 4100 DUE TO, OR AS A CONSEQUENCE OF (b) Possible myocardial infarction Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 1 hr 1 hr						
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)						
19a. DATE OF OPERATION ---		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED ---		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR --- 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)		
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE		
22a. I certify that (I) this hospital attended the deceased from 2/4 , 19 82 to 2/4 , 19 82 , that (we) last saw the deceased alive on 2/4 , 19 82 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) did not view the body after death.						
22b. SIGNATURE James W. Young		DEGREE MD		22c. DATE SIGNED 2/4/82		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) James W. Young		22e. ADDRESS Johns Hopkins Hosp. Balto 21205				
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 2/8/82		23c. NAME OF CEMETERY OR CREMATORY St. Stanislaus Cem.		
24. FUNERAL DIRECTOR NAME George A. Weber & Sons Inc.		ADDRESS 705 S. Ann St.		25a. DATE REC'D. BY REGISTRAR FEB 5 1982		
		25b. REGISTRAR'S SIGNATURE James W. Young				



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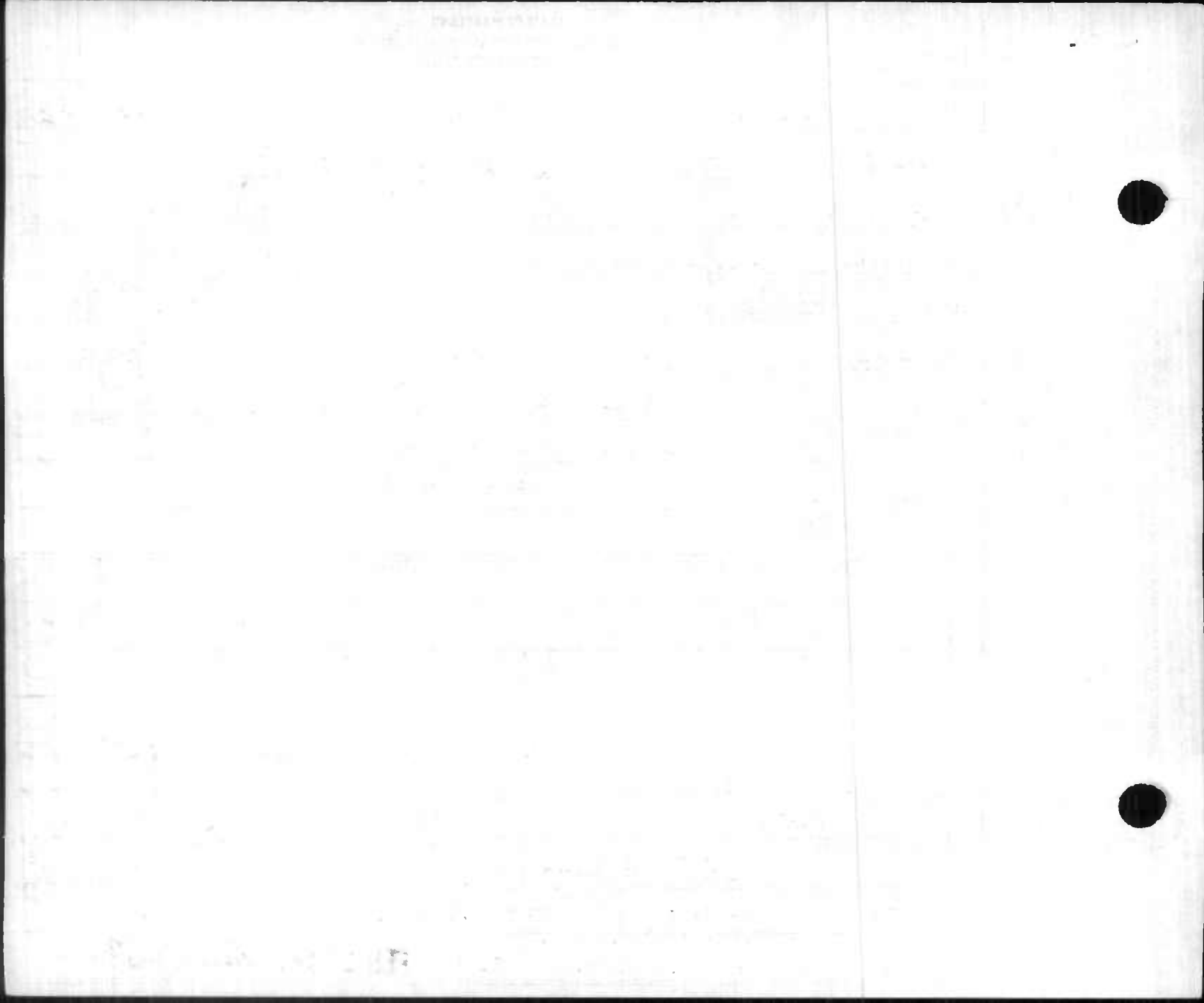
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				8 2 0 3 5 5 5			
1. FOR STATE REGISTRAR				REG. NO.			
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST AARON BLOCK			2a. DATE OF DEATH MONTH DAY YEAR 2-12-82			2b. HOUR 9:00 M	
3. SEX MALE	4. RACE WHITE	5. DATE OF BIRTH MONTH DAY YEAR 2 25 1913		6. AGE (IN YEARS LAST BIRTHDAY) 68 YRS		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MARYLAND	7b. CITIZEN OF WHAT COUNTRY? U.S.	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE CITY MD			
10. CITY OR TOWN OF DEATH BALTIMORE	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) LEVINDALE HEBREW GERIATRIC HOSPITAL			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) NONE		12b. KIND OF BUSINESS OR INDUSTRY NONE	
13a. STATE MD		13b. COUNTY BALTIMORE	13c. CITY OR TOWN BALTIMORE	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET ADDRESS 1620 MORELAND AVE. #21216		
14. FATHER'S NAME FIRST MIDDLE LAST ABRAHAM BLOCK			15. MOTHER'S MAIDEN NAME FIRST MIDDLE MINNIE SHERR				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO		16b. SOCIAL SECURITY NO. 216-82-1636		17. INFORMANT MRS. BETTY FRUMAN #20852 6111 MONTROSE RD., APT. 324 ROCKVILLE, MD			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) ACUTE INFERIOR MYOCARDIAL INFARCTION 4100 DUE TO, OR AS A CONSEQUENCE OF A.S.C.V.D. Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from 4-13 19 81 to 2-12 19 82, that (I) (we) last saw the deceased alive on 3-13 19 82, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE Hyler W				DEGREE		22c. DATE SIGNED 2-12-82	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) SET HTWAR				22e. ADDRESS Levindale Hebrew Geriatric Ctr Hosp. 2434 W. Belvedere, Baltimore Md. 21215			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL		23b. DATE 2-14-82		23c. NAME OF CEMETERY OR CREMATORY TIFERETH ISRAEL CONG.		23d. LOCATION ROSEDALE BALTO. MD	
24. FUNERAL DIRECTOR SOL LEVINSON & BROS., INC. NAME ADDRESS 6010 REISTERSTOWN RD., BALTO., MD 21215				25a. DATE REC'D. BY REGISTRAR FEB 17 1982		25b. REGISTRAR'S SIGNATURE [Signature]	



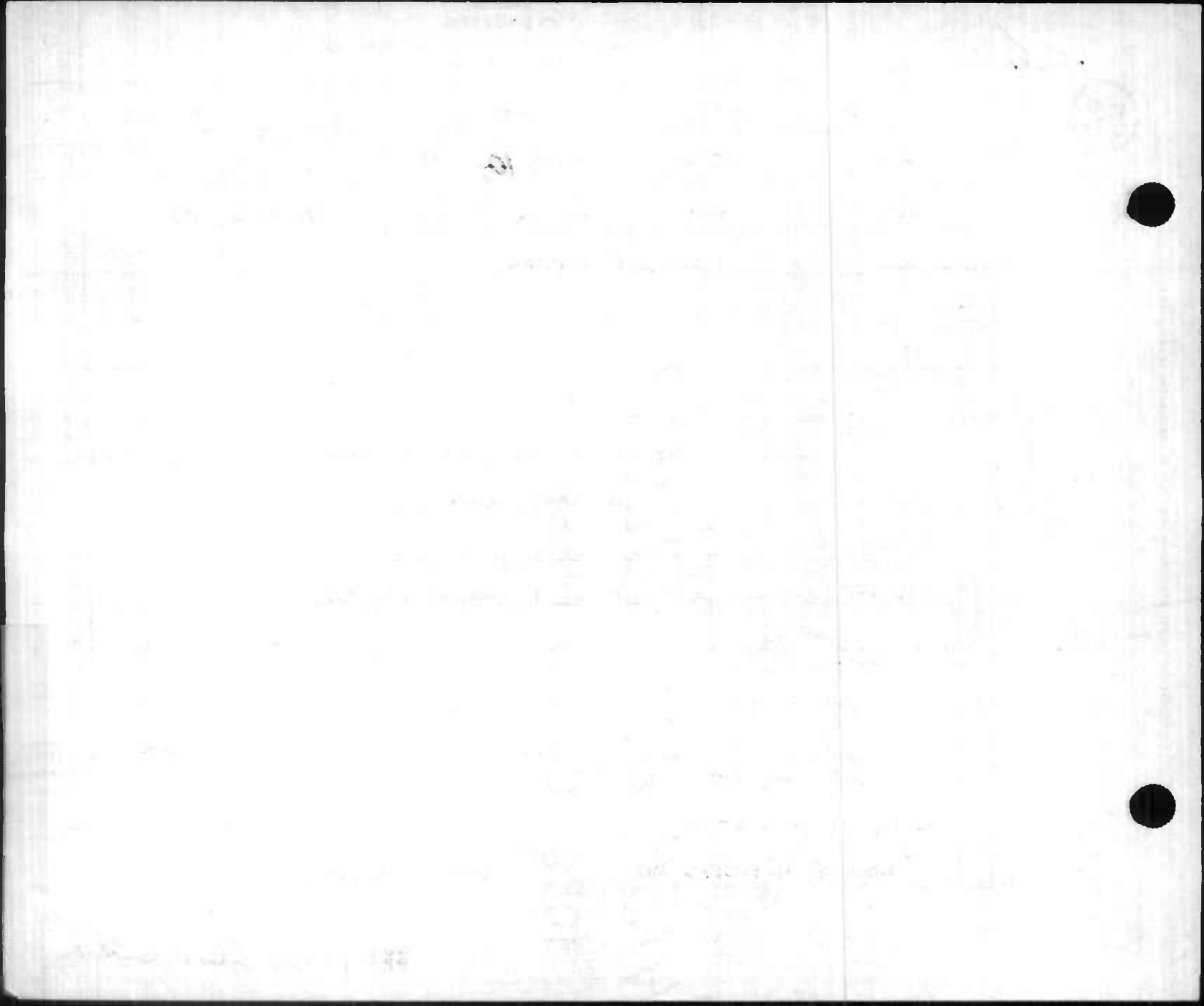
STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 2 0 3 5 5 6

1. FOR STATE REGISTRAR		REG. NO.	
1. DECEASED NAME (TYPE OR PRINT) Marie Elizabeth Block		2a. DATE OF DEATH 2 10 82	
3. SEX Female		4. RACE Caucasian	
5. DATE OF BIRTH Sept. 10, 1896		6. AGE (IN YEARS LAST BIRTHDAY) 85 YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MD.		7b. CITIZEN OF WHAT COUNTRY? USA	
8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE CITY MD.	
10. CITY OR TOWN OF DEATH Baltimore		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) LUTHERAN HOSPITAL	
12a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 12a. STATE Maryland 12b. COUNTY Baltimore 12c. CITY OR TOWN Baltimore		12d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
13a. FATHER'S NAME Toby Hahn		13b. MOTHER'S MAIDEN NAME (unknown)	
14a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) no		14b. SOCIAL SECURITY NO. 217-18-8163	
15. INFORMANT Mrs. Carole Rickards		ADDRESS 4131 Buckingham Rd. Baltimore, Maryland 21207	
16. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CHRONIC MYELOMONOCYTIC LEUKEMIA DUE TO, OR AS A CONSEQUENCE OF (b) SEVERE PANCYTOPENIA DUE TO, OR AS A CONSEQUENCE OF (c)		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 11/81	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: MILD LEFT FOCAL SEIZURES / FEVER OF UNKNOWN ETIOLOGY			
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	
20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19	
21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)		21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	
21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (in this hospital) attended the deceased from 1:17, 19 82, to 2:10, 19 82, that (we) last saw the deceased alive on 2:10, 19 82, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.			
22b. SIGNATURE Raymond H. Flores		DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>	
22c. DATE SIGNED 2-10-82		22d. ADDRESS Lutheran Hospital	
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 2-12-82	
23c. NAME OF CEMETERY OR CREMATORY Lake View Mem. Park		23d. LOCATION CITY OR TOWN COUNTY STATE Sykesville Carroll Maryland	
24. FUNERAL DIRECTOR NAME Loring Byers Funeral Directors Inc. ADDRESS 8728 Liberty Road Randallstown, Maryland 21133		25a. DATE REC'D. BY REGISTRAR FEB 11 1982	
25b. REGISTRAR'S SIGNATURE Thomas J. Smith			

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 1 and 2 should be filed within 72 hours after death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death. with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.



RELEASED NON-MED. DR. V. DOLAN PER MR. GREGORY
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

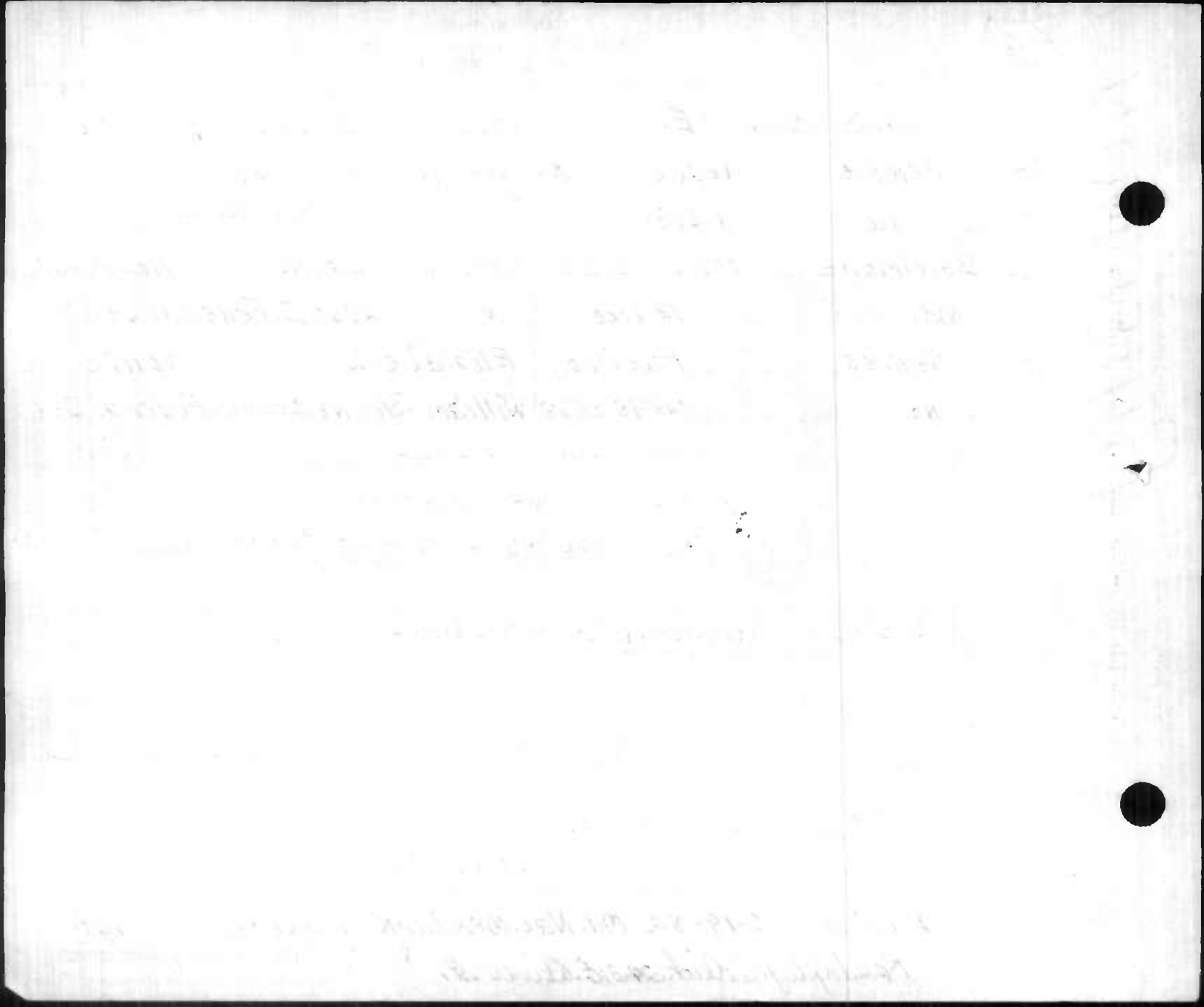
STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 2 0 3 5 5 7

FOR
1 - STATE
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Mabel MABLE E. BLOUNT			2a. DATE OF DEATH MONTH DAY YEAR FEBRUARY 15 1982		2b. HOUR 3:38 PM
3. SEX Female	4. RACE Negro	5. DATE OF BIRTH MONTH DAY YEAR 2-20-21		6. AGE (IN YEARS LAST BIRTHDAY) 60 YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Va	7b. CITIZEN OF WHAT COUNTRY? U.S.A.	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE CITY MD	
10. CITY OR TOWN OF DEATH Baltimore	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) JOHNS HOPKINS HOSPITAL		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) L.P.N.		12b. KIND OF BUSINESS OR INDUSTRY Hospital
13a. STATE md.		13b. CITY OR TOWN Balta	13c. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13d. STREET ADDRESS 2850 E. Federal St.	
14. FATHER'S NAME FIRST MIDDLE LAST Vellies Patillo		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Elizabeth Nellie			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. 218-18-8838		17. INFORMANT William Blount	
18. CAUSE OF DEATH (Enter only one cause per line for 1a, 1b, and 1c) PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) RIGHT HEART FAILURE 4149 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) CARDIAC SURGERY CABG + MVR DUE TO, OR AS A CONSEQUENCE OF (c) IHD MITRAL REGURG PULM H/T TRICUSPID REGURG. 1 MONTH APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH HOURS					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: 0					
19a. DATE OF OPERATION 2/15/82		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED CORONARY ART DKS, MITRAL REGURG		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (1) (this hospital) attended the deceased from 2/15/82 to 2/15/82 that (1) was lost saw the deceased alive on 2/15/82 and that in (my) own opinion death occurred on the date and hour and from the causes stated above, (1) was (did) (did not) view the body after death					
22b. SIGNATURE Dr. Nixon		DEGREE MDBS FRACS		22c. DATE SIGNED 2/15/82	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) NIXON		22e. ADDRESS JOHNS HOPKINS HOSPITAL			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 2-19-82		23c. NAME OF CEMETERY OR CREMATORY MD. Nat. Mem Park	
23d. LOCATION CITY OR TOWN Laurel		23e. COUNTY MD.		23f. STATE MD.	
24. FUNERAL DIRECTOR NAME Randolph J. Collick		ADDRESS 24315 Oliver St.		25a. DATE REC'D. BY REGISTRAR FEB 18 1982	
25b. REGISTRAR'S SIGNATURE Thomas J. [Signature]					



FOR
1 - STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

8 2 0 3 5 5 8

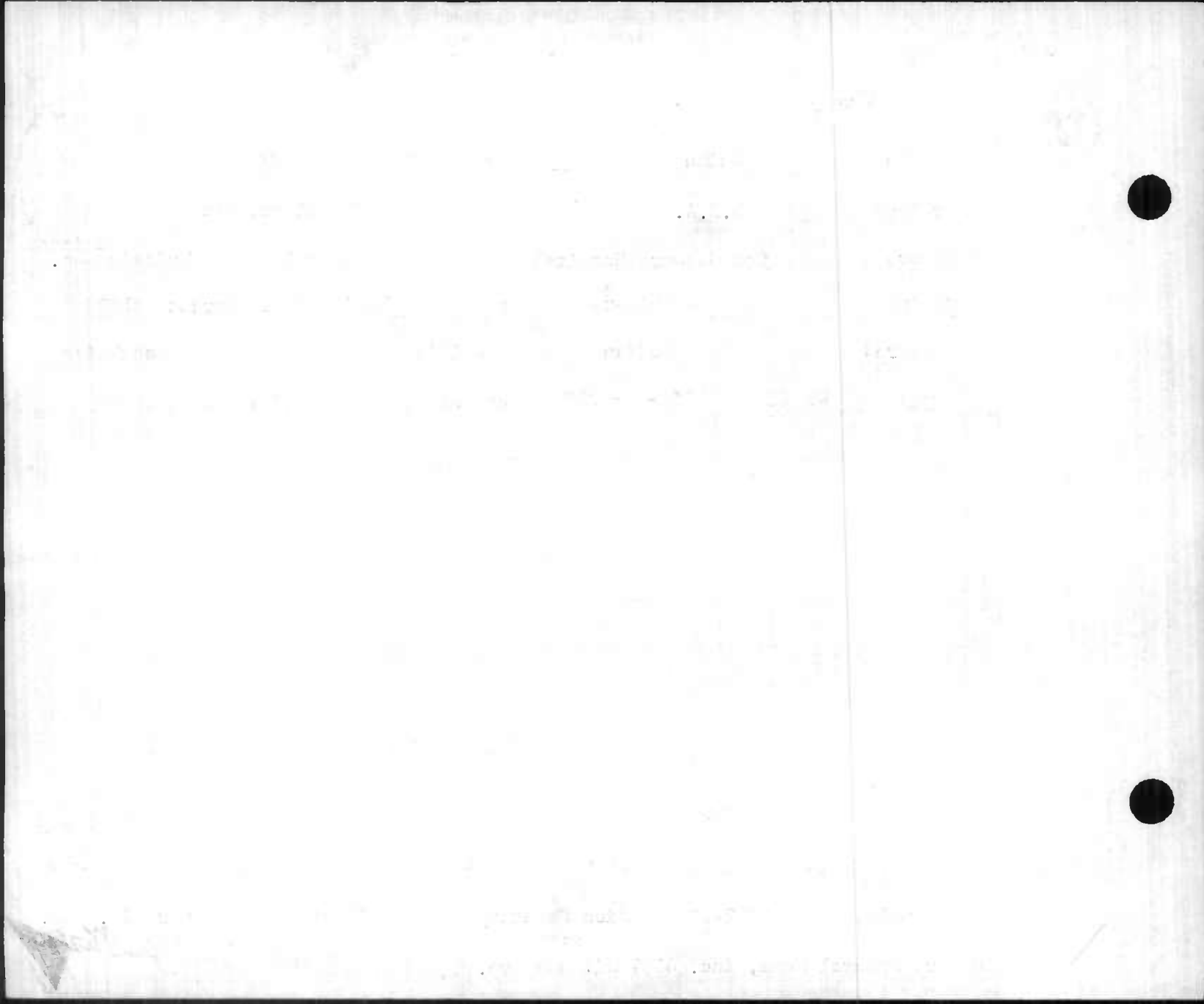
1. DECEASED NAME (TYPE OR PRINT)		2a. DATE OF DEATH		2b. HOUR	
Theodore A. Boffen		02 19 82		3:00 P.M.	
1. SEX	4. RACE	5. DATE OF BIRTH		6. AGE (IN YEARS LAST BIRTHDAY)	
Male	White	11 20 16		65 YRS	
7. BIRTHPLACE (STATE OR FOREIGN COUNTRY)	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH	
Maryland	U.S.A.			Baltimore City MD.	
10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY
Baltimore	Con Secours Hospital		Mechanic		Tricking Co.
13a. STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS?	13e. STREET ADDRESS	
Maryland		Baltimore	YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	1525 Ridgley Street 21230	
14. FATHER'S NAME		15. MOTHER'S MAIDEN NAME			
Alfred Boffen		Emilie Mattheiss			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS	
YES		WW II 220-07-8329		Anna Knight 3807 Coolidge Avenue, 21229	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CA of lung = metastasis</u> 1629 DUE TO, OR AS A CONSEQUENCE OF (b) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (c) _____ DUE TO, OR AS A CONSEQUENCE OF					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY?	
				YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (his hospital) attended the deceased from <u>3/19</u> 19 <u>82</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.		13/24 19 81 to 3/19 19 82			
22b. SIGNATURE Kuang-yen Huang		DEGREE M.D.		22c. DATE SIGNED 3/19/82	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) KUANG-YEN HUANG		22e. ADDRESS BON SECOURS HOSPITAL			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 2/22/82	23c. NAME OF CEMETERY OR CREMATORY Zion Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE Elkridge Howard Co. Md.
24. FUNERAL DIRECTOR NAME Hubbard Funeral Home, Inc. 4107 Wilkens Ave.		24b. ADDRESS 21229		25a. DATE REC'D. BY REGISTRAR FEB 23 1982	
				25b. REGISTRAR'S SIGNATURE Frances Jean Nathan	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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FOR
1 - STATE
REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 2 0 3 5 5 9

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Mary E. Bolden			2a. DATE OF DEATH MONTH DAY YEAR 2- 6- 82		2b. HOUR M
3. SEX Female	4. RACE Blk	5. DATE OF BIRTH MONTH DAY YEAR 2- 25- 28	6. AGE (IN YEARS LAST BIRTHDAY) 53 YRS.	7. IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MD	7b. CITIZEN OF WHAT COUNTRY? U.S.A	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH City MD.		
10. CITY OR TOWN OF DEATH Balto	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 4102 Borman Ave.		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY
13a. STATE MD			13b. COUNTY	13c. CITY OR TOWN Balto	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
14. FATHER'S NAME FIRST MIDDLE LAST George F. Jackson			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Gussie Bolden		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 220-20-9860	17. INFORMANT ADDRESS Earl Bolden 4102 Borman Ave.		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>acute MI</u> 4100 DUE TO, OR AS A CONSEQUENCE OF (b) <u>hypertension</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO, OR AS A CONSEQUENCE OF (c) _____					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>acute</u> <u>12-20</u>
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) _____					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from <u>9</u> 19 <u>70</u> to <u>present</u> 19 <u>82</u> , that (I) (we) last saw the deceased alive on <u>4/21</u> 19 <u>81</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did not) view the body after death.					
22b. SIGNATURE <u>Leon G. Stieglitz, M.D.</u>		DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED <u>2/8/82</u>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) LEON G. STIEGLITZ, M.D.		22e. ADDRESS 6705 PAAM HEIGHTS AVE			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial	23b. DATE 2- 11- 82	23c. NAME OF CEMETERY OR CREMATORY Mt. Auburn Cem.		23d. LOCATION CITY OR TOWN COUNTY STATE Balto.	
24. FUNERAL DIRECTOR NAME Vernon R. Bailey 1348 N. Calhoun St.			25a. DATE REC'D. BY REGISTRAR FEB 9 1982		





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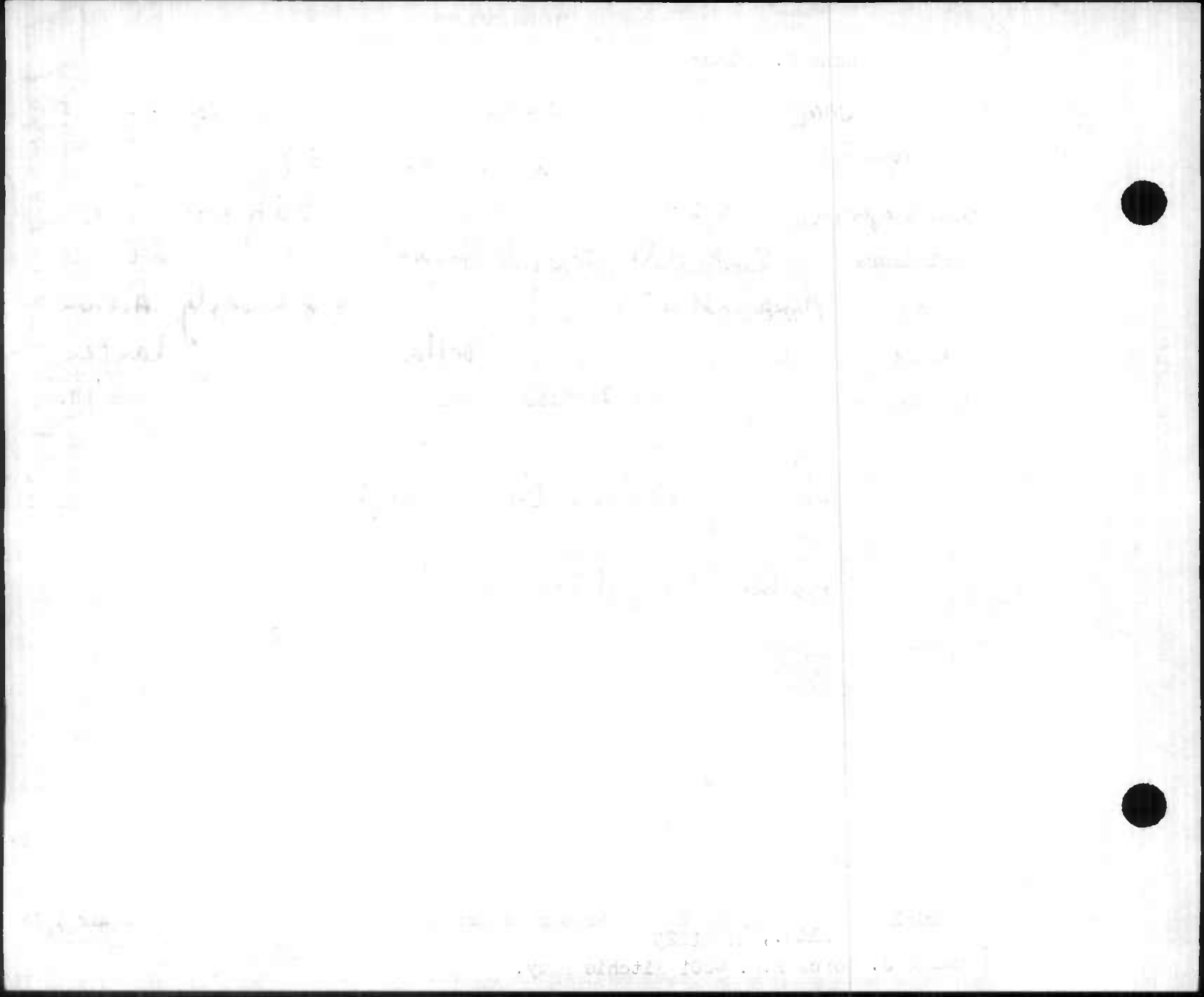
FOR STATE REGISTRAR **Jane M. Bolton**

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

8 2 0 3 5 6 0

1. DECEASED NAME (TYPE OR PRINT) JANE M BOLTON			2a. DATE OF DEATH MONTH DAY YEAR 2 23 82		2b. HOUR 11:55P
3. SEX Female	4. RACE White	5. DATE OF BIRTH MONTH DAY YEAR 6 2 22		6. AGE (IN YEARS LAST BIRTHDAY) 59	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) West Virginia		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	
9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore MD		10. CITY OR TOWN OF DEATH Baltimore		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) South Balt. General Hospital	
12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Assembly		12b. KIND OF BUSINESS OR INDUSTRY East Tools		13a. STREET ADDRESS 418 Waverly Avenue.	
13b. STATE md.		13c. CITY OR TOWN Baltimore		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST Kent Evans		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Della Lantz		16. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) UNKNOWN	
16b. SOCIAL SECURITY NO. 219-22-5382		17. INFORMANT Denzil G. Bolton		ADDRESS Spring City, PA. 85 W. Seven Stars Rd.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: 1629 IMMEDIATE CAUSE (a) Respiratory Arrest DUE TO, OR AS A CONSEQUENCE OF (b) Recurrent CA @ Lungs DUE TO, OR AS A CONSEQUENCE OF (c) Possible Congestive Failure.					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			
21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22. I certify that (1) this hospital attended the deceased from 2/12 , 19 82 , to 2/23 , 19 82 , that (1) we last saw the deceased alive on 2/23 , 19 82 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above (1) we (we) did (did not) view the body after death.					
22b. SIGNATURE Gerard M. Lowder		DEGREE M.D.M.D.		22c. DATE SIGNED 2/24/82	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) GERARD M. LOWDER		22e. ADDRESS South Balt. General Hospital.			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 2/27/82		23c. NAME OF CEMETERY OR CREMATORY Barbour Memorial	
23d. LOCATION CITY OR TOWN COUNTY STATE Baltimore, Md. 21225		23e. DATE REC'D. BY REGISTRAR FEB 25 1982		23f. REGISTRAR'S SIGNATURE Charles Santhorn	
24. FUNERAL DIRECTOR NAME ADDRESS George J. Gonce F.H. 4001 Ritchie Hgwy.					



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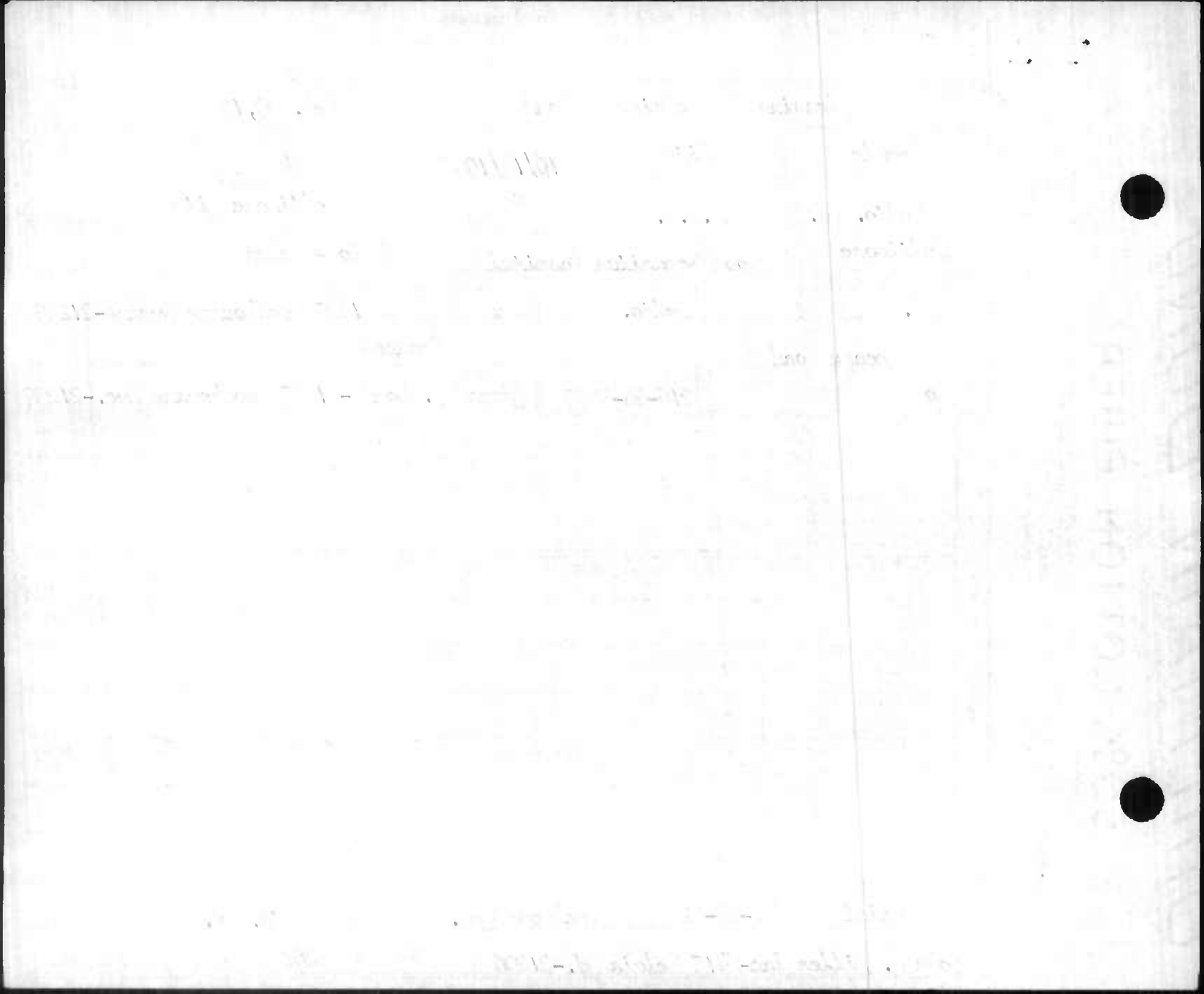
IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 2 0 3 5 6 1

REG. NO.

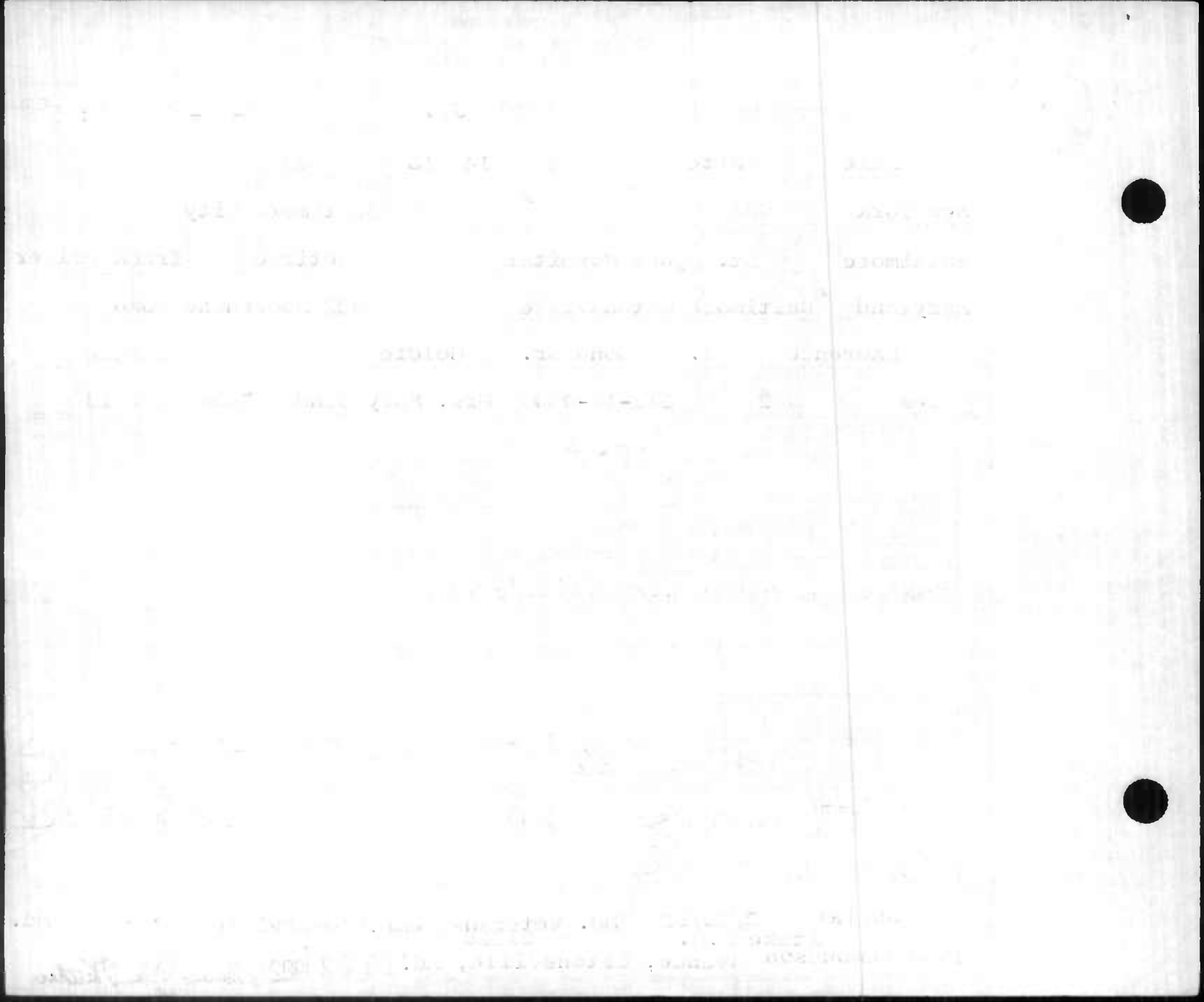
1. DECEASED NAME (TYPE OR PRINT) <i>Blessina Hedwige Bond</i>			2a. DATE OF DEATH MONTH DAY YEAR <i>Feb. 23, 1982</i>		2b. HOUR M
3. SEX <i>Female</i>	4. RACE <i>White</i>	5. DATE OF BIRTH MONTH DAY YEAR <i>10/14/1907</i>		6. AGE (IN YEARS LAST BIRTHDAY) YRS. MONTHS DAYS <i>74</i>	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <i>Balto. Md.</i>	7b. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <i>Baltimore City</i> MD.	
10. CITY OR TOWN OF DEATH <i>Baltimore</i>	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <i>Good Samaritan Hospital</i>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <i>Home Maker</i>		12b. KIND OF BUSINESS OR INDUSTRY
13a. STATE <i>Md.</i>			13b. COUNTY <i>Balto.</i>	13c. CITY OR TOWN <i>Balto.</i>	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
14. FATHER'S NAME FIRST MIDDLE LAST <i>George Bond</i>			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <i>Frances</i>		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <i>No</i>		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) <i>216-28-5979</i>		17. INFORMANT ADDRESS <i>Eduard E. Bond - 1625 Woodbourne Ave. - 21239</i>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Hypertensive c-v. disease</i> <i>4029</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>arteriosclerosis</i> (c) <i>arteriosclerosis</i> DUE TO, OR AS A CONSEQUENCE OF DUE TO, OR AS A CONSEQUENCE OF					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			
21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <i>P.M. 19</i>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from <i>Dec. 5</i> , 19 <i>70</i> , to <i>Dec. 12</i> , 19 <i>81</i> , that (I) (we) lost saw the deceased alive on <i>Dec. 12</i> , 19 <i>81</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE <i>Romulo V. Goco</i>		DEGREE <i>M.D.</i>		22c. DATE SIGNED <i>2/26/82</i>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <i>Romulo V. Goco, M.D.</i>		22e. ADDRESS <i>5500 Bowleys LANE 21206</i>			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <i>Burial</i>		23b. DATE <i>2-27-82</i>		23c. NAME OF CEMETERY OR CREMATORY <i>Parkwood Cem.</i>	
23d. LOCATION CITY OR TOWN COUNTY STATE <i>Balto. Md.</i>		24. FUNERAL DIRECTOR NAME ADDRESS <i>John C. Miller Inc-6415 Belair Rd. - 21206</i>			
25a. DATE REC'D. BY REGISTRAR <i>MAR 1 1982</i>		25b. REGISTRAR'S SIGNATURE <i>Frances Jane Nathan</i>			



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 must be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours of the death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										REG. NO. 8-2-03562	
1. FOR STATE REGISTRAR		1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Lawrence E Bond Jr.				2a. DATE OF DEATH MONTH DAY YEAR 2-22-82		2b. HOUR 7:45 AM			
3 SEX Male		4 RACE White		5. DATE OF BIRTH MONTH DAY YEAR 4 14 18		6 AGE (IN YEARS LAST BIRTHDAY) 63 YRS		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) New York		7b. CITIZEN OF WHAT COUNTRY? USA		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH Baltimore City MD.					
10 CITY OR TOWN OF DEATH Baltimore		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) St. Agnes Hospital				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Retired		12b. KIND OF BUSINESS OR INDUSTRY Truck Driver			
13a. STATE Maryland		13b. COUNTY Baltimore		13c. CITY OR TOWN Catonsville		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS 6022 Moorehead Road			
14 FATHER'S NAME FIRST MIDDLE LAST Lawrence E. Bond Sr.		15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Goldie Fleagle									
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) Yes WW2		16b. SOCIAL SECURITY NO. 213-16-0509		17 INFORMANT ADDRESS Mrs. Mary Bond Same as # 13							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: 0389 IMMEDIATE CAUSE (a) Sepsis. DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) Anoxic Encephalopathy, Myocardial Infarction											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE							
22a. I certify that (I) (this hospital) attended the deceased from 2-7-82 to Feb 22 1982 that (I) (we) lost saw the deceased alive on Feb 22 1982, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) not view the body after death.											
22b. SIGNATURE Oscar Hernandez				DEGREE M.D.				ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 2-22-82	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Oscar Hernandez				22e. ADDRESS							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 2/25/82		23c. NAME OF CEMETERY OR CREMATORY Md. Veterans Home		23d. LOCATION CITY OR TOWN COUNTY STATE Crownsville A.A. Md.					
24 FUNERAL DIRECTOR Witzke P.A. 1630 Edmondson Avenue, Catonsville, Md				25a. DATE REC'D. BY REGISTRAR FEB 22 1982		25b. REGISTRAR'S SIGNATURE James J. Nathan					



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after the death and that it be signed by the physician or other qualified person. It may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the records after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

BP

DHMH-16 50M 1/81
(VRA 15, 4)1- FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST AUDREY RUTH BORD			2a. DATE OF DEATH MONTH DAY YEAR 2-10-82		2b. HOUR 1:55 AM
3. SEX FEMALE	4. RACE W. HITE	5. DATE OF BIRTH MONTH DAY YEAR 1 16 1915		6. AGE (IN YEARS LAST BIRTHDAY) 67 YRS.	IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MARYLAND	7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		
9. BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE CITY MD.			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) HOUSEWIFE		
10. CITY OR TOWN OF DEATH BALTIMORE			12b. KIND OF BUSINESS OR INDUSTRY AT HOME		
11. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE MARYLAND 13b. COUNTY CARROLL 13c. CITY OR TOWN SYKESVILLE 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/> 13e. STREET ADDRESS 7200 3rd AVE. #21784					
14. FATHER'S NAME FIRST MIDDLE LAST A. HARRY GOLDSTEIN			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST AUDREY N. WELCH		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO		16b. SOCIAL SECURITY NO. 220-03-6809		17. INFORMANT ADDRESS DR. KENNETH KRACKOW 26 ARVERNE CT. TIMONIUM, MD 21093	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1. DEATH CAUSED BY: 1629 Respiratory arrest DUE TO, OR AS A CONSEQUENCE OF Carcinoma of lung 2-3 mths Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO, OR AS A CONSEQUENCE OF Chronic Obstructive Lung Disease					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			
21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK OR NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			
21f. LOCATION STREET CITY OR TOWN COUNTY STATE		22a. I certify that (I) (this hospital) attended the deceased from 1-14-82 to 2-10-82 , that (I) (we) lost 2-10-82 1:55 AM saw the deceased alive on 2-10-82 above, (I) (we) (did) (did not) view the body after death.			
22b. SIGNATURE VASEEM MALIK		DEGREE MD		22c. DATE SIGNED 2/10/82	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) VASEEM MALIK		22e. ADDRESS GOOD SAMARITAN HOSP., BALTIMORE, MD			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL		23b. DATE FEB. 12, 1982		23c. NAME OF CEMETERY OR CREMATORY CHIZUK AMUNO	
23d. LOCATION BALTIMORE		COUNTY MARYLAND			
24. FUNERAL DIRECTOR NAME SOL LEVINSON & BROS., INC.		25a. DATE REC'D. BY REGISTRAR FEB 17 1982		25b. REGISTRAR'S SIGNATURE <i>Thomas J. [Signature]</i>	
26. ADDRESS 6010 REISTERSTOWN RD. BALTO., MD 21215					

MEDICAL CERTIFICATION

SEP 14 1954

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

DHMH - 16 50M 1/81
(VRA 15, 4)

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 2 0 3 5 6 4

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) JUANITA MAE BOSS		2a. DATE OF DEATH MONTH DAY YEAR 2/13/82		2b. HOUR 8 aM	
3. SEX Female	4. RACE White	5. DATE OF BIRTH MONTH DAY YEAR 3 11 14		6. AGE (IN YEARS LAST BIRTHDAY) 67 YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	
9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore		10. CITY OR TOWN OF DEATH Baltimore		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 103 N. Rock Glen Rd Apt "A"	
12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Homemaker		12b. KIND OF BUSINESS OR INDUSTRY Own Home		13a. STREET ADDRESS 103 N. Rock Glen Rd. Apt A	
13b. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13c. CITY OR TOWN Baltimore		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST Ernest W. Marling		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Martha Nixon		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No	
16b. SOCIAL SECURITY NO. 219-05-8213		17. INFORMANT Jeannette Kolbe Same as #13		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 4292 A S C ✓ D DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19	
21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)		21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	
21f. LOCATION STREET CITY OR TOWN COUNTY STATE		22a. I certify that (I) (this hospital) attended the deceased from 19 73, to 2/10 19 82, that (I) (we) lost saw the deceased alive on 2/10 19 82, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.		22b. SIGNATURE Edgar P. Williamson 2nd M.D.	
22c. DATE SIGNED 2/15/82		22d. PHYSICIAN'S NAME (TYPE OR PRINT) Edgar P. Williamson II		22e. ADDRESS Baltimore, Md. 21228 5550 Baltimore National Pike	
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 2/16/82		23c. NAME OF CEMETERY OR CREMATORY Loudon Park Cem	
23d. LOCATION CITY OR TOWN COUNTY STATE Baltimore Maryland		24. FUNERAL DIRECTOR NAME Witzke, P.A. ADDRESS 1630 Edmondson Ave Catonsville, Md.		25. DATE REC'D. BY REGISTRAR 25b. REGISTRAR'S SIGNATURE FEB 16 1982 Charles Jan Nathan	

MEDICAL CERTIFICATION

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 1b. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. GIVE PAGE 4 TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR RECORDS. IF THE DEATH IS SUSPECTED TO BE A BURIAL - TRANSIT PERMIT, PAGES 1 AND 2 SHOULD BE FILED, WITHIN 24 HOURS OF DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

FOR REGISTRAR		1- REGISTRAR	
1. DECEASED NAME (TYPE OR PRINT)		2b. DATE KNOWN OF DEATH ESTIMATED	
JAMES T. BOYD		MONTH DAY YEAR 2 6 19 82	
3. SEX	4. RACE	5. DATE OF BIRTH	6. AGE (IN YEARS)
male	negro	MONTH DAY YEAR 6 30 16	65 YRS
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?	
South Boston, Va.		USA	
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)	
Baltimore		517 N. Arlington Ave.	
12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY	
13a. STATE		13b. COUNTY	
Md.		Balto.	
14. FATHER'S NAME		15. MOTHER'S MAIDEN NAME	
Tom Boyd		Mable	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)		16b. SOCIAL SECURITY NO.	
No			
17. INFORMANT		ADDRESS	
Shirley Boyd		505 N. Arlington Ave.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: 4029 IMMEDIATE CAUSE (a) Hypertensive & arteriosclerotic cardiovascular disease Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. (b) _____ (c) _____ DUE TO, OR AS A CONSEQUENCE OF		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).			
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?	
20. AUTOPSY?		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19	
21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)	
		21f. LOCATION CITY OR TOWN COUNTY STATE	
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> .			
ACTUAL SIGNATURE		TITLE (SPECIFY)	
Ann M. Dixon, M.D.		Assistant MEDICAL EXAMINER	
EXAMINER'S NAME (TYPE OR PRINT)		DATE SIGNED	
		2-7-82	
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE	
Burial		2/11/82	
23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION CITY OR TOWN COUNTY STATE	
MARTIN L. KING PK		BALTO., MD.	
24. FUNERAL DIRECTOR NAME		25a. DATE REC'D. BY REGISTRAR	
EROY O. DYETT 4600 LIBERTY HEIGHTS AVE.		FEB 8 1982	
ADDRESS		25b. REGISTRAR'S SIGNATURE	
		Name Jan. North	



TO HOSPITAL OR ATTENDING PHYSICIAN. The low requires that this certificate be executed within 24 hours of death and retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

BP

DHMH - 16 50M 1/B1
(VRA 15, 4)

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										REG. NO.			
1. DECEASED NAME (TYPE OR PRINT) MICHAEL LEE BOYD										2a. DATE OF DEATH MONTH DAY YEAR 2/28/82		2b. HOUR 10:13A	
3. SEX MALE		4. RACE CAUC.		5. DATE OF BIRTH MONTH DAY YEAR DEC. 19, 1953		6. AGE (IN YEARS LAST BIRTHDAY) 28		IF UNDER 1 YEAR MONTHS DAYS YRS.		IF UNDER 24 HRS. HOURS MIN. YRS.			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MARYLAND		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE CITY MD.							
10. CITY OR TOWN OF DEATH BALTIMORE		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) JOHNS HOPKINS HOSPITAL				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) MAINTENANCE		12b. KIND OF BUSINESS OR INDUSTRY COCHRAN OIL					
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) STATE COUNTY CITY OR TOWN MARY LAND KENT GALENA				13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS							
14. FATHER'S NAME FIRST MIDDLE LAST GEORGE J. BOYD SR.				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST DOROTHY SMITH									
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) YES				16b. SOCIAL SECURITY NO. (IF KNOWN) VIET NAM 219-60-0980		17. INFORMANT ADDRESS GEORGE J. BOYD SR. father- same							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Cardiopulmonary arrest 2023 DUE TO, OR AS A CONSEQUENCE OF (b) Histiocytic Medullary Reticulosis DUE TO, OR AS A CONSEQUENCE OF (c)										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) Gastrointestinal hemorrhage, Renal failure													
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)									
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE									
22a. I certify that (I) (this hospital) attended the deceased from 2/23 , 19 82 , to 2/28 , 19 82 , that (I) (we) last saw the deceased alive on 2/28 , 19 82 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.													
22b. SIGNATURE Susan D. Wolfthal MD				DEGREE MD				ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		22c. DATE SIGNED 2/28/82			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) SUSAN D. WOLFTHAL				22e. ADDRESS Johns Hopkins Hospital									
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL		23b. DATE 3-3-82		23c. NAME OF CEMETERY OR CREMATORY GALENA CEMETERY		23d. LOCATION (IF KNOWN) GALENA KENT COUNTY MARYLAND							
24. FUNERAL DIRECTOR NAME EDW. FELLOWS AND SON MILLINGTON, MD						25. DATE REC'D. BY REGISTRAR MAR 8 1982		25b. REGISTRAR'S SIGNATURE <i>[Signature]</i>					

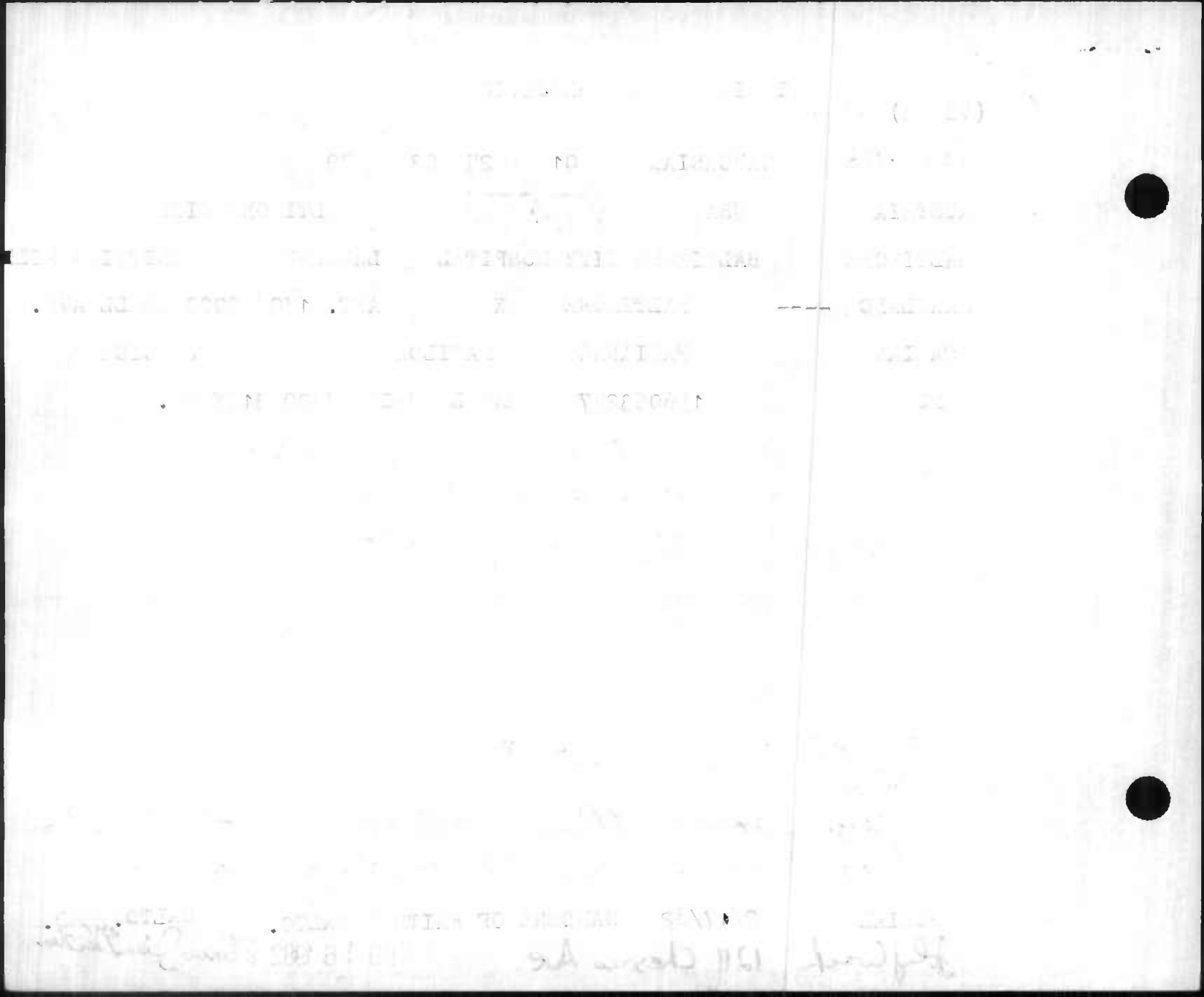
0214

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the registrar, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed in the office after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				8 2 0 3 5 6 7 REG. NO.			
1. DECEASED NAME (TYPE OR PRINT) WINNIE BRAJEVICH (VINKA) WINNIE BRATEVICH				2a. DATE OF DEATH MONTH DAY YEAR 2 14 82			
3 SEX FEMALE				2b. HOUR 1045 P.M.			
4 RACE CAUCASIAN		5. DATE OF BIRTH MONTH DAY YEAR 01 29 03		6. AGE (IN YEARS LAST BIRTHDAY) 79 YRS		IF UNDER 1 YEAR IF UNDER 74 HRS MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) AUSTRIA		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE CITY MD	
10. CITY OR TOWN OF DEATH BALTIMORE		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) BALTIMORE CITY HOSPITAL		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) LABORER		12b. KIND OF BUSINESS OR INDUSTRY KNITTING MIL	
13a. STATE MARYLAND		13b. COUNTY ---		13c. CITY OR TOWN BALTIMORE		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST FABIAN FABIANAC		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST MATILDA JERCICH		13e. STREET ADDRESS APT. 1707 2000 ODELL AVE.			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO		16b. SOCIAL SECURITY NO. 156053247		17. INFORMANT ADDRESS HAROLD REICH 7900 31ST ST.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH CAUSED BY: IMMEDIATE CAUSE (a) CARDIORESPIRATORY ARREST 4100 DUE TO, OR AS A CONSEQUENCE OF (b) A-V dissociation Conditions, if any, which gave rise to immediate cause (c), stating the underlying cause last (c) Myocardial infarct				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18. PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (1) (this hospital) attended the deceased from 2/10 19 82 to 2/14 19 82 , that (1) (we) last saw the deceased alive on 2/14 19 82 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (If they did not view the body after death, view the body after death.)							
22b. SIGNATURE Mary Sprache MD DEGREE				22c. DATE SIGNED 2/15/82			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Mary Sprache				22e. ADDRESS Balto City Hospitals			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL		23b. DATE 2/17/82		23c. NAME OF CEMETERY OR CREMATORY GARDENS OF FAITH		23d. LOCATION CITY OR TOWN COUNTY STATE BALTO BALTO MD	
24. FUNERAL DIRECTOR Jef Cook ADDRESS 1211 Chesaco Ave.				25a. DATE REC'D. BY REGISTRAR FEB 16 1982 25b. REGISTRAR Thomas Jan Parker			



STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 2 0 3 5 6 8

REG. NO.

FOR
STATE
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) ALBERTA Alverta Branch		2a. DATE OF DEATH MONTH DAY YEAR 2/12/82		2b. HOUR 6:00 AM
3. SEX F	4. RACE B	5. DATE OF BIRTH MONTH DAY YEAR 4 15 1900		6. AGE (IN YEARS LAST BIRTHDAY) 81 YRS
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Va.	7b. CITIZEN OF WHAT COUNTRY? U. S. A.	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE CITY MD.
10. CITY OR TOWN OF DEATH Baltimore	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) North Charles General Hospital		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) ---	12b. KIND OF BUSINESS OR INDUSTRY ---
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) Md.		13b. COUNTY BA No.	13c. CITY OR TOWN Baltimore	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
14. FATHER'S NAME Chester Nash		15. MOTHER'S MAIDEN NAME Sara H Temple		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) ---		16b. SOCIAL SECURITY NO. 212-36-9757		
17. INFORMANT Gwendolyn Stepney		ADDRESS 12 B Cedar Hgt Ct.		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: 5850 IMMEDIATE CAUSE (a) urinary tract infection DUE TO, OR AS A CONSEQUENCE OF: (b) chronic renal failure DUE TO, OR AS A CONSEQUENCE OF: (c) ---				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)				
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>
20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE
22. I certify that (I) (this hospital) attended the deceased from 10/20 19 81 to 2/12 19 82, that (I) (we) last saw the deceased alive on 2/12 19 82, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (If (we) (did) (did not) view the body after death.)				
22a. SIGNATURE Marcos B. Galicia Jr., MD		DEGREE MD		22b. DATE SIGNED 2/12/82
22c. PHYSICIAN'S NAME (TYPE OR PRINT) MARCOS B. GALICIA Jr., MD		22d. ADDRESS North Charles GEN Hosp.		
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 2/15/82		23c. NAME OF CEMETERY OR CREMATORY Mt Auburn Cemetery
23d. LOCATION CITY OR TOWN Baltimore		STATE Maryland		
24. FUNERAL DIRECTOR NAME Law Funeral Home		ADDRESS 4611 Park Heights Ave.		25a. DATE REC'D. BY REGISTRAR FEB 25 1982
25b. REGISTRAR'S SIGNATURE Thomas J. [Signature]				

MEDICAL CERTIFICATION

9 9

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

x

Indicate "yes" or "no" for:

 Σ

X

Figure 1

2. T ≤ 2

[10]

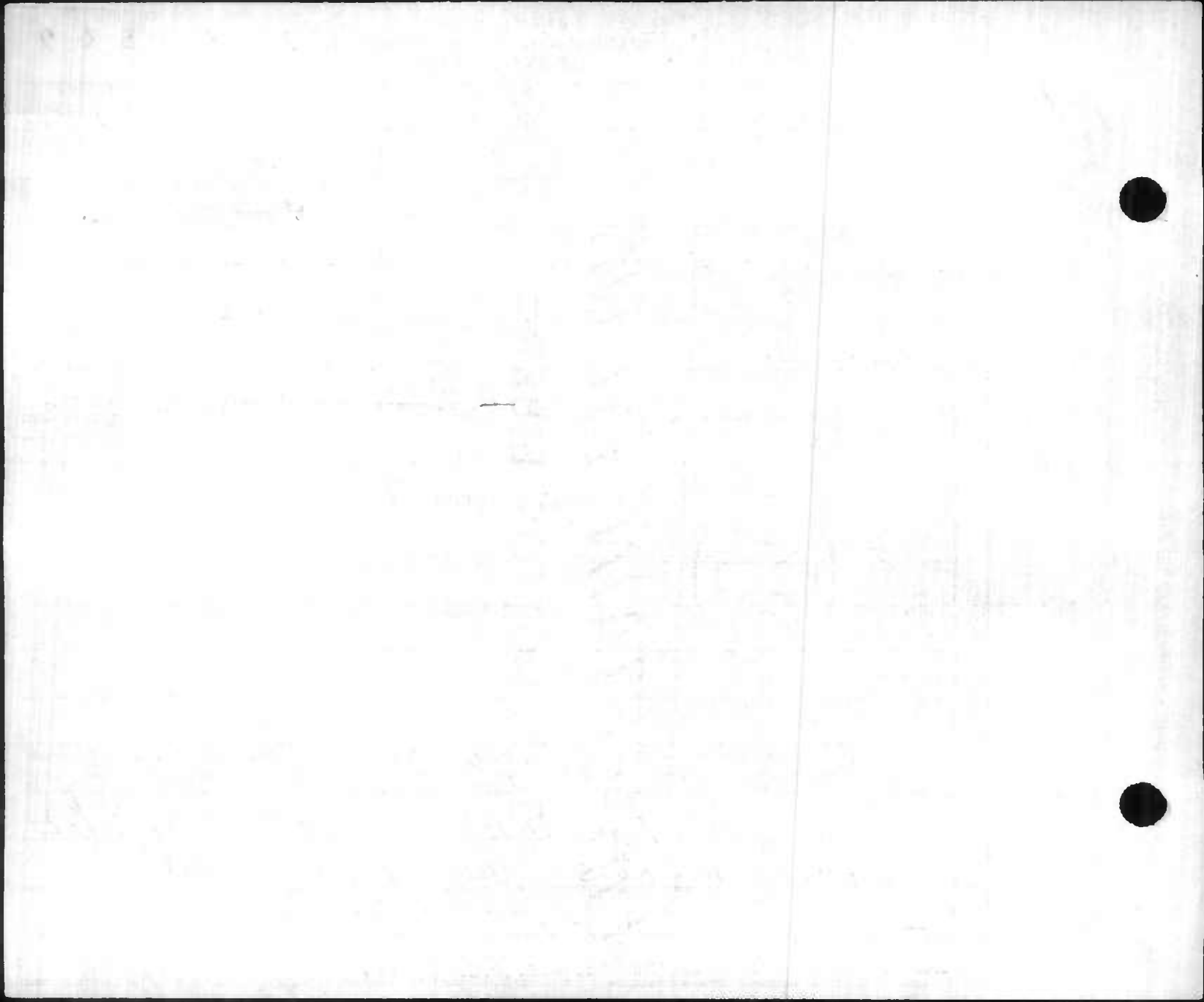
[illegible]

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

FOR STATE REGISTRAR		Items, 9, 17, & 23c., G-565		STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE		8 2 0 3 5 6 9	
1- STATE REGISTRAR		3/30/82, by Da./ Gbj.		CERTIFICATE OF DEATH		REG. NO.	
1. DECEASED NAME (TYPE OR PRINT)		FIRST MIDDLE LAST Elvora M. Branch		2a. DATE OF DEATH MONTH DAY YEAR 2/20/82		2b. HOUR 10 ⁵⁵ AM	
3. SEX Female		4. RACE Negro		5. DATE OF BIRTH MONTH DAY YEAR Apr 8, 1913		6. AGE (IN YEARS LAST BIRTHDAY) 68 YRS	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) N. C.		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City, MD.	
10. CITY OR TOWN OF DEATH Baltimore		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 160 Shadyside Road		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Teacher/Librarian		12b. KIND OF BUSINESS OR INDUSTRY Unknown	
13a. STATE Md		13b. COUNTY		13c. CITY OR TOWN Baltimore		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST John Wilson Mills		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Lula Campbell		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. 579-24-8392	
17a. INFORMANT Miss Johnnell		17b. ADDRESS Branch/daughter/same as 13e		17c. DATE SIGNED 2/20/82		17d. SIGNATURE Warren M. Ross	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Edema 1919 DUE TO, OR AS A CONSEQUENCE OF (b) Malignant Brain Tumor DUE TO, OR AS A CONSEQUENCE OF (c)		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 1					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from July 19 81, to Feb 20 19 82, that (I) (we) lost saw the deceased alive on Jan 19 82, and that in my (our) opinion death occurred on the date and hour and from the causes stated above (I) (we) (did) (did not) view the body after death.							
22b. PHYSICIAN'S NAME (TYPE OR PRINT) WARREN M. ROSS		22c. ADDRESS Charm Memorial Hospital		22d. DATE SIGNED 2/20/82		22e. SIGNATURE Warren M. Ross	
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 2-24-82		23c. NAME OF CEMETERY OR CREMATORY Church Pleasant Ridge		23d. LOCATION CITY OR TOWN COUNTY STATE Gastonia, N. C.	
24. FUNERAL DIRECTOR NAME John T. Rhines Co.,		ADDRESS 3015 12th St., N.E., D.C.		25a. DATE REC'D. BY REGISTRAR Feb 6 1982		25b. REGISTRAR'S SIGNATURE John T. Rhines	



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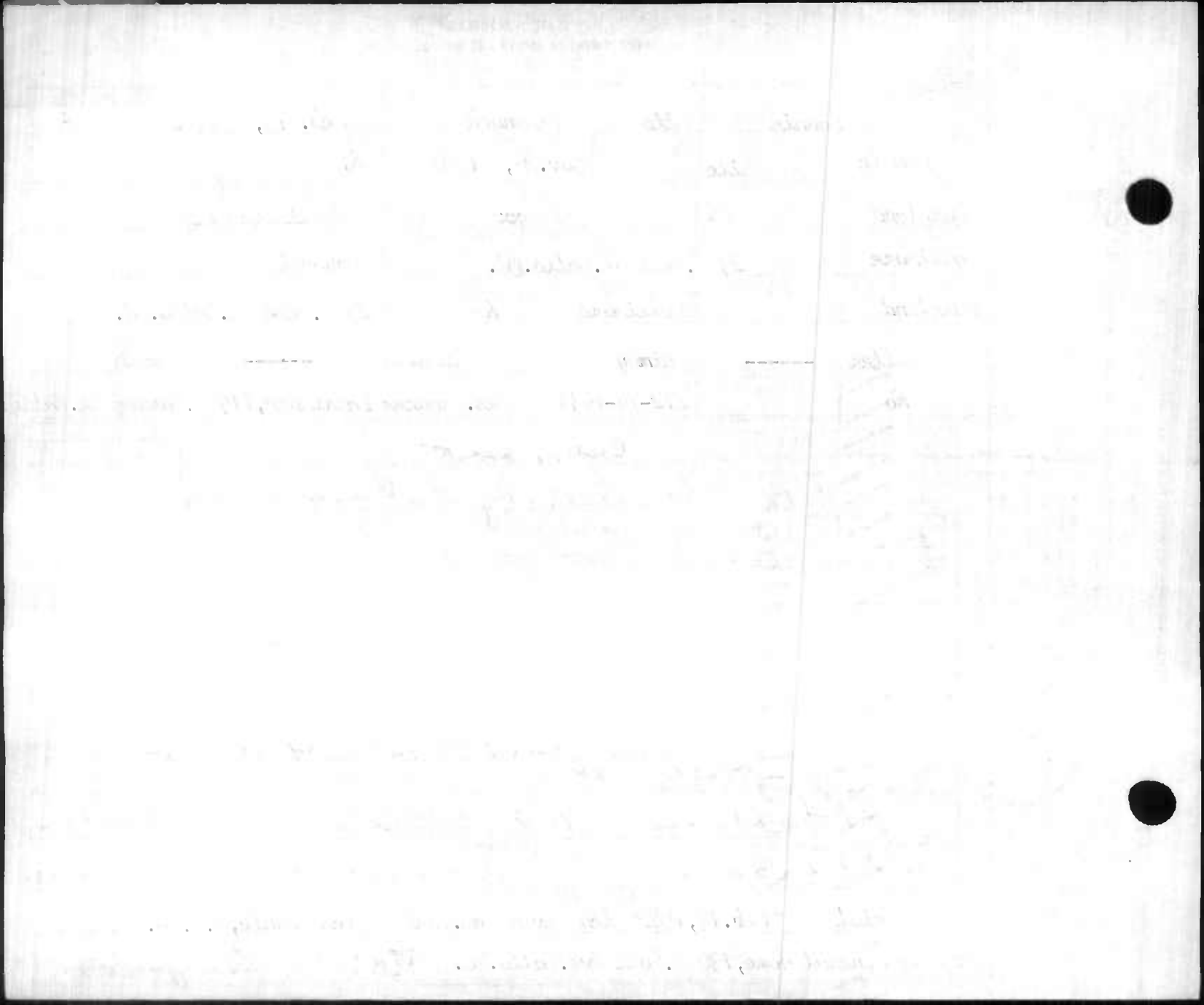
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FOR
1- STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 2 0 3 5 7 0

REG. NO.

1 DECEASED NAME (TYPE OR PRINT) Fannie Etta Brannock			2a DATE OF DEATH MONTH DAY YEAR Feb. 15, 1982		2b HOUR A. M.
3 SEX Female	4 RACE White	5 DATE OF BIRTH MONTH DAY YEAR Nov. 26, 1900	6 AGE (IN YEARS LAST BIRTHDAY) 81	IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.	
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland	7b CITIZEN OF WHAT COUNTRY? USA	8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	9 BALTIMORE CITY OR COUNTY OF DEATH Baltimore City MD.		
10 CITY OR TOWN OF DEATH Baltimore	11 NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 23 W. West St. Balto. Md.		12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Housewife	12b KIND OF BUSINESS OR INDUSTRY	
13a STATE Maryland	13b COUNTY	13c CITY OR TOWN Baltimore	13d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e STREET ADDRESS 23 W. West St. Balto. Md.	
14 FATHER'S NAME FIRST MIDDLE LAST Walter ----- Quimby		15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Juanita ----- Ruark			
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No	16b SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 212-74-1434	17 INFORMANT ADDRESS Mrs. Frances Larrimore, 119 E. Barney St. Balto.			
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Coronary atherosclerosis</u> 4029 DUE TO, OR AS A CONSEQUENCE OF (b) <u>Arteriosclerosis - Hypertension</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO, OR AS A CONSEQUENCE OF (c)					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)					
19a DATE OF OPERATION	19b CONDITION FOR WHICH OPERATION WAS PERFORMED	20a AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19	21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK	21e PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f LOCATION STREET CITY OR TOWN COUNTY STATE			
22a I certify that (I) (this hospital) attended the deceased from <u>12/31</u> , 19 <u>74</u> , to <u>2/15</u> , 19 <u>82</u> , that (I) (we) lost saw the deceased alive on <u>2/23</u> , 19 <u>82</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) saw the body after death.					
22b SIGNATURE <u>H. P. Friedman</u>	DEGREE M.D.	ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>	22c DATE SIGNED 2/16/82		
22d PHYSICIAN'S NAME (TYPE OR PRINT) H. P. FRIEDMAN		22e ADDRESS 1319 L. GALT ST. BALTO. MD. 21235			
23a BURIAL, CREMATION, REMOVAL (SPECIFY) Burial	23b DATE Feb. 19, 1982	23c NAME OF CEMETERY OR CREMATORY Glen Haven Mem. Park	23d LOCATION CITY OR TOWN COUNTY STATE Glen Burnie, A.A. Co. Maryland		
24 FUNERAL DIRECTOR NAME ADDRESS McCutty Funeral Home, 130 E. Fort Ave. Balto. Md.		25a DATE REC'D. BY REGISTRAR FEB 16 1982	25b REGISTRAR'S SIGNATURE <u>Thomas J. Smith</u>		



TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1 - FOR
STATE
REGISTRAR

item 14,15 #G566 4/8/82

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 2 0 3 5 7 1

REG. NO.

1 DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST HAMMOND J. BRISCOE			2a DATE OF DEATH MONTH DAY YEAR 02-12-82		2b HOUR 5:20pm	
3 SEX Male		4 RACE Black		5 DATE OF BIRTH MONTH DAY YEAR 5 7 1895		
6a BIRTHPLACE (STATE OR FOREIGN COUNTRY) Md		6b CITIZEN OF WHAT COUNTRY? USA		6 AGE (IN YEARS LAST BIRTHDAY) YRS MONTHS DAYS HOURS MIN. 86		
7a CITY OR TOWN OF DEATH Balto		7b NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Church Hospital Corp.		7c BALTIMORE CITY OR COUNTY OF DEATH Balto City		
8 USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a STATE Md		8b CITY OR TOWN Balto		8c INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
9 FATHER'S NAME FIRST MIDDLE LAST Joseph UNKNOWN		9b MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Lillian Briscoe		9c ADDRESS 3209 Yosemite Ave		
10 WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) Yes		10b SOCIAL SECURITY NO. 220-46-942		10c INFORMANT Mr Hammond J. Briscoe Jr		
11 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) METASTATIC CANCER 1991 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____						
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) _____						
19a DATE OF OPERATION		19b CONDITION FOR WHICH OPERATION WAS PERFORMED		19c AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
20a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		20c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)		
21a INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21b PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21c LOCATION STREET CITY OR TOWN COUNTY STATE CHH 100 N. BROADWAY BALTO MD		
22 I certify that (I) (this hospital) attended the deceased from 02-11- 19 82 , to 02-12- 19 82 , that (I) (we) lost saw the deceased alive on 02-12- 19 82 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.						
22a SIGNATURE Peter A. Holt MD				22b DATE SIGNED 2/12/82		
22c PHYSICIAN'S NAME (TYPE OR PRINT) Peter A. Holt MD				22d ADDRESS CHH 100 N. BROADWAY BALTO MD		
23a BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b DATE 2/17/82		23c NAME OF CEMETERY OR CREMATORY New Cathedral		
23d LOCATION (CITY OR TOWN) Balto		23e COUNTY Md		23f STATE Md		
24 FUNERAL DIRECTOR NAME Chatman F/H				24b ADDRESS 1701 McCulloch St		
25a DATE REC'D. BY REGISTRAR FEB 16 1982				25b REGISTRAR'S SIGNATURE Thom J. [Signature]		

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25/7/22

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STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 2 0 3 5 7 2

1 - FOR
STATE
REGISTRAR

REG. NO.

| | | | | | |
|---|---|---|---|--|--|
| 1. DECEASED NAME
(TYPE OR PRINT)
FIRST MIDDLE LAST
ANNA S. BRITTINGHAM | | | 2a. DATE OF DEATH
MONTH DAY YEAR
2 21 82
HOUR
6 30 | | |
| 3 SEX
Female | 4 RACE
White | 5. DATE OF BIRTH
MONTH DAY YEAR
8 25 15 | 6 AGE (IN YEARS LAST BIRTHDAY)
66 YRS | 7. UNDER 1 YEAR MONTHS DAYS
7. UNDER 1 YEAR MONTHS DAYS | |
| 7a. BIRTHPLACE
(STATE OR FOREIGN COUNTRY)
Illinois | 7b. CITIZEN OF WHAT COUNTRY?
U.S.A. | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/> | 9. BALTIMORE CITY OR COUNTY OF DEATH
Baltimore City MD. | | |
| 10. CITY OR TOWN OF DEATH
Baltimore | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
Mercy Hospital | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
Office worker | 12b. KIND OF BUSINESS OR INDUSTRY
KAND E | |
| 13a. STATE
Maryland | 13b. CITY OR TOWN
Baltimore | 13c. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | 13d. STREET ADDRESS
21202
222 St. Paul Place Apt. 3106 | | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
Michael P. Swenda | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
Mary Andela | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
NO | 16b. SOCIAL SECURITY NO.
(IF YES, GIVE WAR OR DATES)
062-10-4067 | 17. INFORMANT
ADDRESS
Apt. 3106 21202
Robert L. Swem, Jr. 222 St. Paul Place | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c).)
PART 1. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>Pulmonary Embolus</u>
4151
DUE TO, OR AS A CONSEQUENCE OF
(b) _____
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(c) _____
DUE TO, OR AS A CONSEQUENCE OF
(c) _____ | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)
<u>Metastatic Lung Carcinoma</u> | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input type="checkbox"/> | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | |
| 21d. INJURY OCCURRED
WHERE <input type="checkbox"/> HOT WHITE <input type="checkbox"/>
AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | |
| 22a. I certify that (1) this hospital attended the deceased from <u>2/21/82</u> to <u>2/21/82</u> that (two) <u>2</u> saw the deceased alive on <u>2/21/82</u> and that in my opinion death occurred on the date and hour and from the causes stated above. (If not, state date and hour of death.) | | | | | |
| 22b. SIGNATURE
<u>KC Kuno</u> | | DEGREE
MD
ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | 22c. DATE SIGNED
2/4/82 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
KC Kuno | | 22e. ADDRESS
Mercy Hospital | | | |
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)
Burial | 23b. DATE
2/24/82 | 23c. NAME OF CEMETERY OR CREMATORY
Druid Ridge Cemetery | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
Pikesville Baltimore Md. | |
| 24. FUNERAL DIRECTOR
NAME
Hubbard Funeral Home, Inc. 4107 Wilkens Ave. | | 24b. ADDRESS
21229 | | 25a. DATE REC'D. BY REGISTRAR
FEB 23 1982 | |
| | | 25b. REGISTRAR'S SIGNATURE
Frances Jan Nathan | | | |

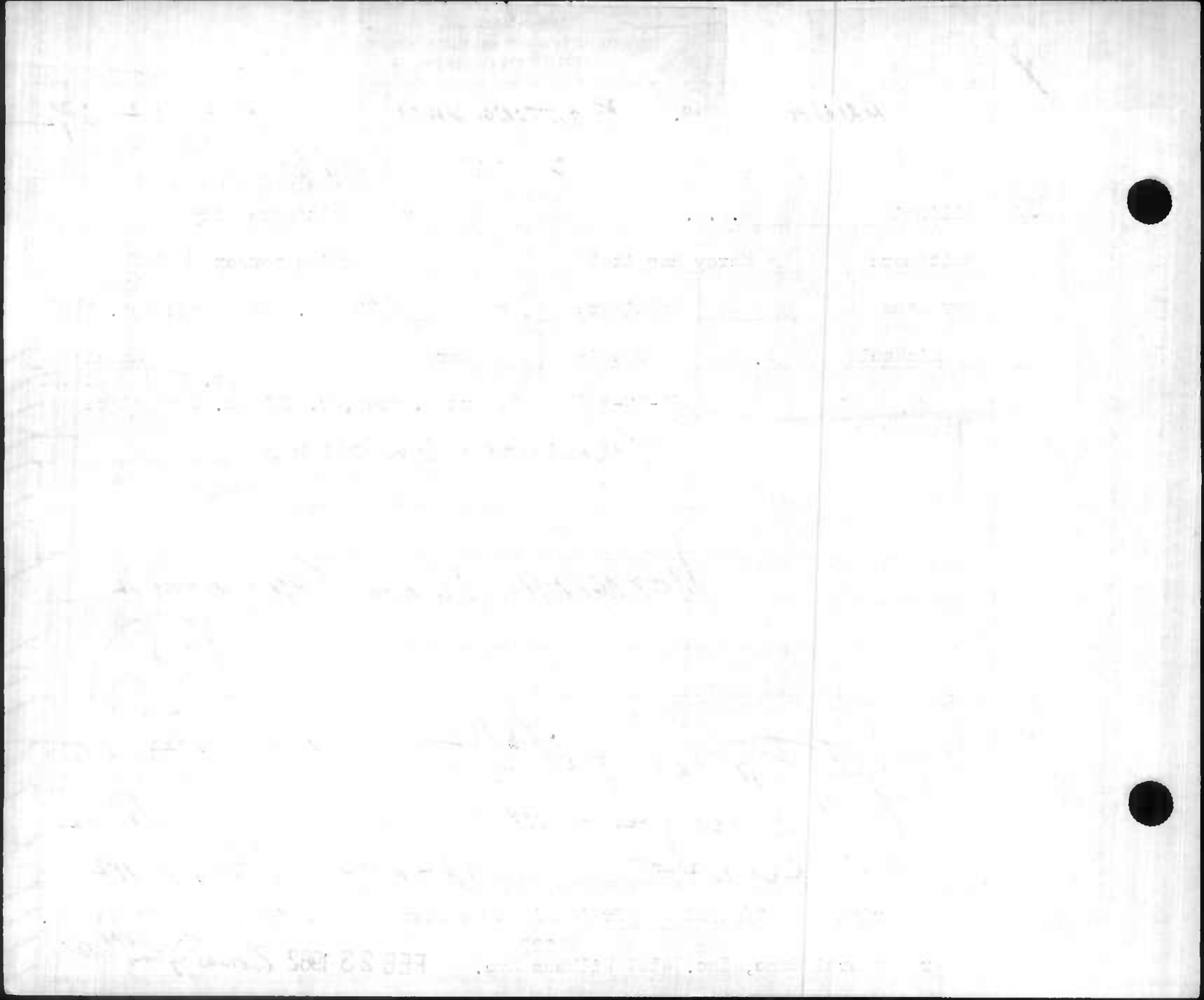
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use on the burial transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

BP

OHMH-16 50M 1/81
(VRA 15, 4)



TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death and retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of cause.

DHMH - 16-50M 1/B1
(VRA 15, 4)FOR
1 - STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | | | | | |
|---|--|--|---|---|--|---|--|--|--|---|--|
| 1. DECEASED NAME
(TYPE OR PRINT) REUBEN BROOK | | | 2a. DATE OF DEATH
MONTH 2 DAY 5 YEAR 82 | | | 2b. HOUR
2:25 P.M. | | | | | |
| 3. SEX
MALE | | 4. RACE
WHITE | | 5. DATE OF BIRTH
MONTH MAR DAY 9 YEAR 19 | | 6. AGE (IN YEARS LAST BIRTHDAY)
62 YRS. | | 7. IF UNDER 1 YEAR
MONTHS DAYS | | 8. IF UNDER 24 HRS.
HOURS MIN. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
MASS. | | 7b. CITIZEN OF WHAT COUNTRY?
US | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
BALTIMORE CITY MD | | | | | |
| 10. CITY OR TOWN OF DEATH
BALTIMORE | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
SINAI HOSPITAL | | | | 12a. OCCUPATION
(USE OF WORK FOR MOST OF WORKING LIFE)
SALESMAN | | 12b. KIND OF BUSINESS OR INDUSTRY
REPAIR SHOPS STEREO EQUIP. | | | |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)
13a. STATE MD 13b. COUNTY BALTO 13c. CITY OR TOWN REISTERSTOWN | | | | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS
7 SAFFRON COURT 21136 | | | | | |
| 14. FATHER'S NAME
FIRST ISAAC MIDDLE LAST BROOK | | | | 15. MOTHER'S MAIDEN NAME
FIRST SADIE MIDDLE LAST ATTOMAN | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN) NO | | | | 16b. SOCIAL SECURITY NO
032-10-2285 | | 17. INFORMANT MRS. MURIEL S. BROOK
7 SAFFRON CT., REISTERSTOWN, MD 21136 | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY
IMMEDIATE CAUSE (a) CARDIAC FAILURE
4292
DUE TO, OR AS A CONSEQUENCE OF
(b) ATHEROSCLEROTIC CARDIOVASCULAR DISEASE
DUE TO, OR AS A CONSEQUENCE OF
(c) | | | | | | | | | | APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATH
30 MIN
10 YEARS | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:
COPD NONE | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED
IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) | | | | | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK | | | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 1/31 , 19 82 , to 2/5 , 19 82 , that (I) (we) lost
saw the deceased alive on 1/31 , 19 82 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated
above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | | | |
| 22b. SIGNATURE
JOHN O. MEYERHOFF, MD | | | | DEGREE
MD | | | | 22c. DATE SIGNED
2/5/82 | | 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
JOHN MEYERHOFF, MD | |
| 22e. ADDRESS
2435 W. BELVEDERE AVE BALTO | | | | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY) BURIAL | | | | 23b. DATE
FEB. 8, 1982 | | 23c. NAME OF CEMETERY OR CREMATORY
OHEB SHALOM MEM. PARK | | 23d. LOCATION
REISTERSTOWN CO. BALTO. MD | | | |
| 24. FUNERAL DIRECTOR
NAME SOL LEVINSON & BROS., INC.
6010 REISTERSTOWN RD. BALTO., MD 21215 | | | | | | 25a. DATE REC'D. BY REGISTRAR FEB 11 1982 25b. REGISTRAR'S SIGNATURE
Frances Jean Nathan | | | | | |

MEDICAL CERTIFICATION

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1

0000 BP

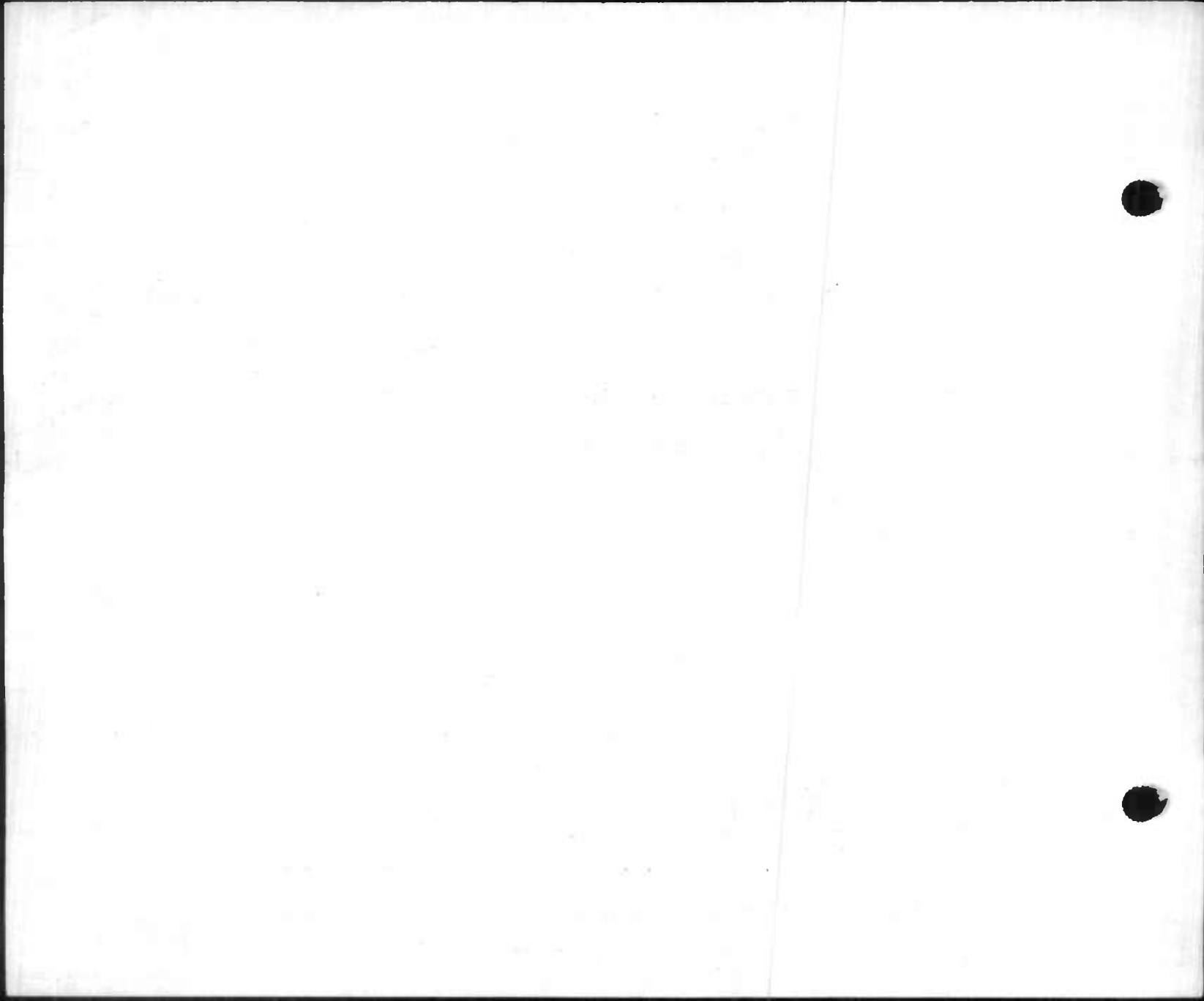


TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 1b. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 77 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | | | | | | | | | | | | | | | |
|--|--|---------|--|---|--|------------------------------------|--|---|--|---|--|---|--|--|--|-------|--|--|--|----------|--|
| FOR
1- STATE REGISTRAR | | | | | | | | | | 8 2 0 3 5 7 4 | | | | | | | | | | | |
| 1. DECEASED NAME
(TYPE OR PRINT) | | | | | | | | | | 2a. DATE KNOWN OF DEATH | | | | | | | | | | 2b. HOUR | |
| CHARLES T RUXTON BROOKS | | | | | | | | | | 2. DATE KNOWN OF DEATH ESTIMATED
2 6 19 82 | | | | | | | | | | M | |
| 3. SEX | | 4. RACE | | 5. DATE OF BIRTH | | 6. AGE (IN YEARS) | | IF UNDER 1 YR. | | IF UNDER 24 HRS. | | 7c. DATE PRONOUNCED DEAD | | 2d. HOUR | | | | | | | |
| male | | white | | 3/15/1913 | | 68 YRS. | | MONTHS | | DAYS | | 2 6 19 82 | | 4:46 | | | | | | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) | | | | 7b. CITIZEN OF WHAT COUNTRY? | | | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> | | | | 9. BALTIMORE CITY OR COUNTY OF DEATH | | | | | | | | | |
| Maryland | | | | U.S.A. | | | | WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | | | Baltimore City MD. | | | | | | | | | |
| 10. CITY OR TOWN OF DEATH | | | | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | | | | 12b. KIND OF BUSINESS OR INDUSTRY | | | | | | | | | |
| Baltimore | | | | University Hospital | | | | Self-employed | | | | Retail Pkg.Gds | | | | | | | | | |
| 13a. STATE | | | | 13b. COUNTY | | 13c. CITY OR TOWN | | 13d. INSIDE CITY LIMITS? | | 13e. STREET ADDRESS | | | | | | | | | | | |
| Maryland | | | | Balto. | | Perry Hall | | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 54 Chapel Town Circle | | 21236 | | | | | | | | | |
| 14. FATHER'S NAME | | | | 15. MOTHER'S MAIDEN NAME | | | | | | | | | | | | | | | | | |
| Charles Bowers Brooks | | | | Anna Pearl Brosnahan | | | | | | | | | | | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? | | | | 16b. SOCIAL SECURITY NO. | | | | 17. INFORMANT | | | | ADDRESS | | | | | | | | | |
| Yes | | | | WW II (Navy) | | | | 212.03.0812 | | | | Kaye B. Bushel 115 Croydon Rd. Baltimore, Maryland 21212 | | | | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) | | | | | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | | | | | | |
| PART I DEATH WAS CAUSED BY: | | | | | | | | | | | | | | | | | | | | | |
| IMMEDIATE CAUSE (a) Multiple injuries | | | | | | | | | | | | | | | | | | | | | |
| DUETO, OR AS A CONSEQUENCE OF | | | | | | | | | | | | | | | | | | | | | |
| Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause lost. | | | | | | | | | | | | | | | | | | | | | |
| (b) | | | | | | | | | | | | | | | | | | | | | |
| DUETO, OR AS A CONSEQUENCE OF | | | | | | | | | | | | | | | | | | | | | |
| (c) | | | | | | | | | | | | | | | | | | | | | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: | | | | | | | | | | | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | | | | | | | | 20. AUTOPSY? | | | | | | | | | |
| | | | | | | | | | | | | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | | | | | | | |
| 21a. EXTERNAL CAUSE WAS | | | | 21b. TIME OF INJURY | | | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2) | | | | | | | | | | | | | |
| UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH | | | | 3:10 P.M. 2-6-1982 | | | | Driver in auto/auto collision. | | | | | | | | | | | | | |
| 21d. INJURY OCCURRED | | | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) | | | | 21f. LOCATION | | | | STATE | | | | | | | | | |
| WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/> | | | | road | | | | Joppa Rd. & White Cliff Lane, Balto. | | | | Md. | | | | | | | | | |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> . Inspection <input type="checkbox"/> . Inquiry <input type="checkbox"/> . and in my opinion death resulted from: Natural causes <input type="checkbox"/> . Accident <input checked="" type="checkbox"/> . Suicide <input type="checkbox"/> . Homicide <input type="checkbox"/> . Undetermined manner <input type="checkbox"/> . | | | | | | | | | | | | | | | | | | | | | |
| ACTUAL SIGNATURE | | | | TITLE (SPECIFY) | | | | DATE SIGNED | | | | | | | | | | | | | |
| Ann M. Dixon, M.D. | | | | M.D. Assistant MEDICAL EXAMINER | | | | 2-7-82 | | | | | | | | | | | | | |
| EXAMINER'S NAME (TYPE OR PRINT) | | | | ADDRESS | | | | | | | | | | | | | | | | | |
| Ann M. Dixon, M.D. | | | | 111 Penn St. | | | | | | | | | | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) | | | | 23b. DATE | | 23c. NAME OF CEMETERY OR CREMATORY | | | | 23d. LOCATION | | | | COUNTY | | STATE | | | | | |
| Cremation | | | | 2/8/1982 | | Green Mount Crematory | | | | Baltimore | | | | Maryland | | | | | | | |
| 24. FUNERAL DIRECTOR | | | | ADDRESS | | | | 25. DATE REG'D. BY REGISTRAR | | | | 26. REGISTRAR'S SIGNATURE | | | | | | | | | |
| Walter Brooks Bradley | | | | 1 nc. Balto. Md 21222 | | | | FEB 9 1982 | | | | [Signature] | | | | | | | | | |

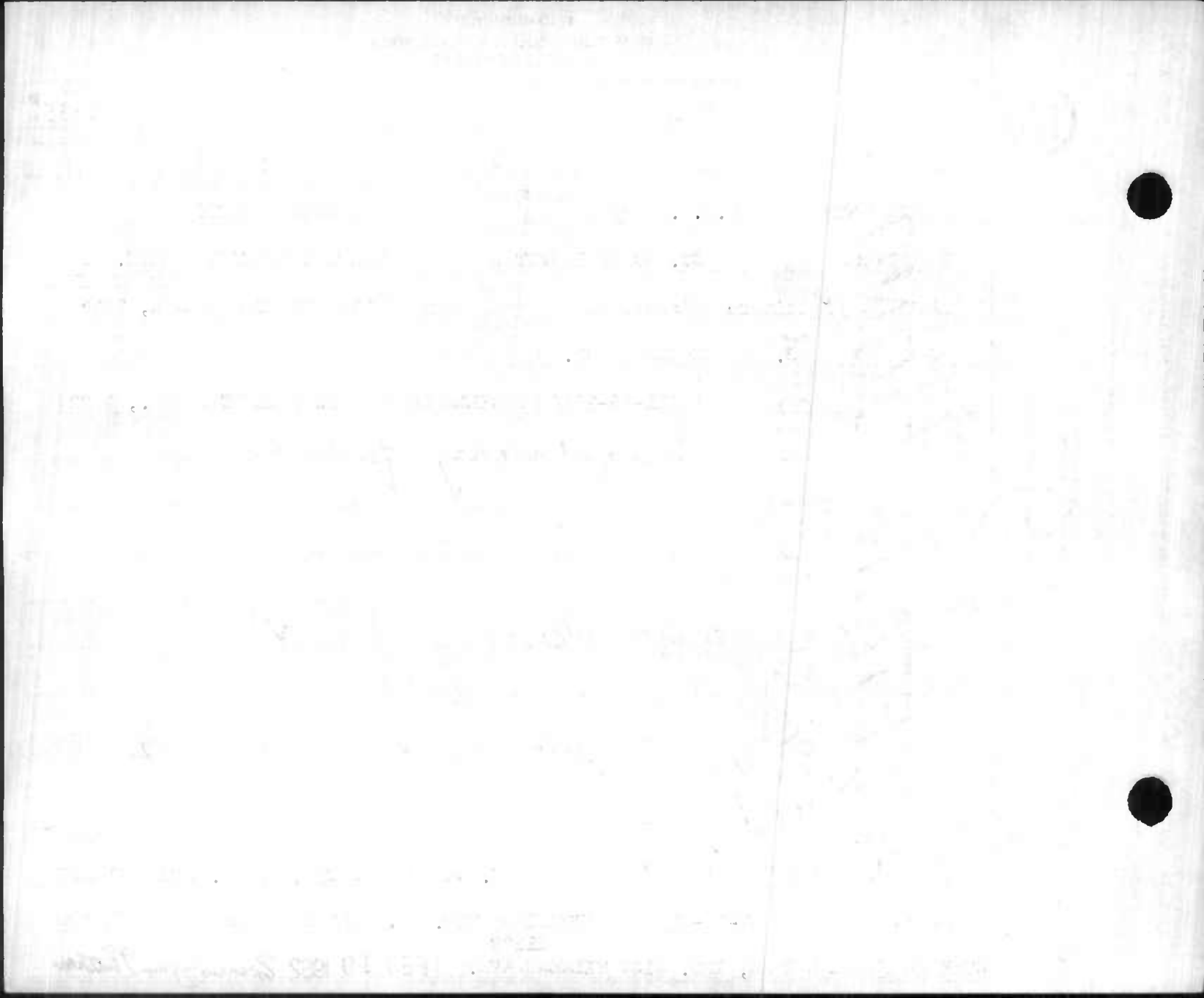


TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified by the funeral director.

| STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH | | | | | | | | | |
|---|--|---|--|---|--|---|--|--|--|
| 1. FOR
STATE
REGISTRAR | | REG. NO. 8 2 0 3 5 7 5 | | | | | | | |
| 1. DECEASED NAME
(TYPE OR PRINT)
FIRST MIDDLE LAST
JOHN JAMES BROOKS | | | | | | 2a. DATE OF DEATH
MONTH DAY YEAR
02 17 82 | | 2b. HOUR
1:35 PM | |
| 3. SEX
MALE | | 4. RACE
WHITE | | 5. DATE OF BIRTH
MONTH DAY YEAR
04 19 08 | | 6. AGE (IN YEARS LAST BIRTHDAY)
73 YRS. | | IF UNDER 1 YEAR
MONTHS DAYS
IF UNDER 24 HRS.
HOURS MIN. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
MASSACHUSETTS | | 7b. CITIZEN OF WHAT COUNTRY?
U.S.A. | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
BALTIMORE CITY MD. | | | |
| 10. CITY OR TOWN OF DEATH
BALTIMORE | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
ST. AGNES HOSPITAL | | | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
MEAT INSPECTOR | | 12b. KIND OF BUSINESS OR INDUSTRY
DEPT. OF | |
| 13a. STATE
MARYLAND | | 13b. COUNTY
Baltimore | | 13c. CITY OR TOWN
Lansdowne | | 13d. INSIDE CITY LIMITS?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 13e. STREET ADDRESS
3207 HILLTOP AVENUE, 21227 | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
JOHN J. BROOKS SR. | | | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
SARA SCANLON | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
NO | | 16b. SOCIAL SECURITY NO.
(IF YES, GIVE WAR OR DATES)
213-26-2686 | | 17. INFORMANT
ADDRESS
LUCILLE BROOKS 3207 HILLTOP AVE., 21227 | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>Cardiopulmonary failure</u>
7070
DUE TO, OR AS A CONSEQUENCE OF
(b) _____
DUE TO, OR AS A CONSEQUENCE OF
(c) _____
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) | | | | | | | | | |
| 19a. DATE OF OPERATION
2/3/82 | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED
Decubitus ulcers | | | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | | | |
| 21d. INJURY OCCURRED
WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>12/17</u> 19 <u>81</u> , to <u>2/17</u> 19 <u>82</u> , that (I) (we) lost
saw the deceased alive on <u>2/17</u> 19 <u>82</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated
above, (I) (we) (did not) view the body after death. | | | | | | | | | |
| 22b. SIGNATURE
<u>Jen Shiang Pan</u> | | | | DEGREE
ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> | | | | 22c. DATE SIGNED
2/17/82 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
JEN SHIANG PAN | | | | 22e. ADDRESS
ST. AGNES HOSPITAL, 900 S. CATON AVENUE | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)
BURIAL | | 23b. DATE
02-20-82 | | 23c. NAME OF CEMETERY OR CREMATORY
MEADOWRIDGE MEM. PK. | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
ELKRIDGE HOWARD MARYLAND | | | |
| 24. FUNERAL DIRECTOR
NAME
HUBBARD FUNERAL HOME, INC. | | | | ADDRESS
4107 WILKENS AVE. | | 25a. DATE REC'D. BY REGISTRAR
FEB 19 1982 | | 25b. REGISTRAR'S SIGNATURE
Frances Jean Nathan | |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death, retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 2 0 3 5 7 6

1- FOR
STATE
REGISTRAR

REG. NO.

| | | | | | | | | | |
|--|--|--|--|---|--|--|--|--|--|
| 1. DECEASED NAME
(TYPE OR PRINT)
Doris Lorraine Branton | | | 2a. DATE OF DEATH
MONTH DAY YEAR
February 18, 1982 | | | 2b. HOUR
3:34PM | | | |
| 3. SEX
Female | | 4. RACE
White | | 5. DATE OF BIRTH
MONTH DAY YEAR
Sept. 1, 1928 | | 6. AGE (IN YEARS (LAST BIRTHDAY))
53 YRS. | | 7. IF UNDER 1 YEAR
MONTHS DAYS
IF UNDER 24 HRS.
HOURS MIN. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
Maryland | | 7b. CITIZEN OF WHAT COUNTRY?
U.S.A. | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
Baltimore City MD. | | | |
| 10. CITY OR TOWN OF DEATH
Baltimore | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
Maryland General Hospital | | | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
Housewife | | 12b. KIND OF BUSINESS OR INDUSTRY
Own Home | |
| 13a. STATE
Maryland | | 13b. COUNTY
A.A. | | 13c. CITY OR TOWN
Severn | | 13d. INSIDE CITY LIMITS?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 13e. STREET ADDRESS
8170 Meade Village Rd. | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
Michael M. Hawk, Sr. | | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
Christina Kraumhauk | | | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)
No N/A | | | |
| 16b. SOCIAL SECURITY NO.
212.28.0982 | | | 17. INFORMANT (Son) ADDRESS Same as # 13
Mr. Vernon L. Tracey | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART 1: DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>Cardiopulmonary Arrest</u>
DUE TO, OR AS A CONSEQUENCE OF
(b) <u>Pneumonia, Sepsis</u>
DUE TO, OR AS A CONSEQUENCE OF
(c) _____
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. | | | | | | | | | |
| PART 2: OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: _____ | | | | | | | | | |
| 19a. DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | |
| 21d. INJURY OCCURRED
WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | |
| 22a. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from February 15, 1982, to February 18, 1982, that <input checked="" type="checkbox"/> (we) lost the deceased alive on February 18, 1982, and that in <input checked="" type="checkbox"/> (our) opinion death occurred on the date and hour and from the causes stated above <input checked="" type="checkbox"/> (we) did <input checked="" type="checkbox"/> view the body after death. | | | | | | | | | |
| 22b. SIGNATURE
Janice Rutkowski, M.D. | | | | | | DEGREE
M.D. | | 22c. DATE SIGNED
February 18, 1982 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
Janice Rutkowski, M.D. | | | | | | 22e. ADDRESS
c/o Maryland General Hospital | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)
Burial | | 23b. DATE
22 Feb. 82 | | 23c. NAME OF CEMETERY OR CREMATORY
Glen Haven Mem.Pk. | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
Glen Burnie, A.A., MD. | | | |
| 24. FUNERAL DIRECTOR
NAME
Singleton Funeral Home | | | | ADDRESS
Glen Burnie, Maryland | | 25a. DATE REC'D. BY REGISTRAR
FEB 23 1982 | | 25b. REGISTRAR'S SIGNATURE
[Signature] | |

30-2-67

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon-papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

| 1. FOR STATE REGISTRAR | | STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH | | 8 2 0 3 5 7 7
REG. NO. | |
|---|--|--|--|--|--|
| 1. DECEASED NAME (TYPE OR PRINT) | | FIRST MIDDLE LAST | | 2a. DATE OF DEATH MONTH DAY YEAR | |
| THOMAS D BRAXTON | | | | 2 2 82 | |
| 3. SEX | | 4. RACE | | 5. DATE OF BIRTH MONTH DAY YEAR | |
| MALE | | NEGRO | | 3 19 49 | |
| 6. BIRTHPLACE (STATE OR FOREIGN COUNTRY) | | 7b. CITIZEN OF WHAT COUNTRY? | | 6. AGE (IN YEARS LAST BIRTHDAY) YRS. | |
| MD | | U.S.A. | | 32 | |
| 10. CITY OR TOWN OF DEATH | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) | | 9. BALTIMORE CITY OR COUNTY OF DEATH | |
| BALTIMORE | | UNION MEMORIAL HOSPITAL | | BALTIMORE CITY MD. | |
| 12a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) | | 13a. INSIDE CITY LIMITS? | | 13b. STREET ADDRESS | |
| 13a. STATE MD | | 13b. YES <input type="checkbox"/> NO <input type="checkbox"/> | | 17455 RIFFLEFORD RD. | |
| 14. FATHER'S NAME FIRST MIDDLE LAST | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST | | 17c. KIND OF BUSINESS OR INDUSTRY | |
| PAUL W. BRAXTON | | JULIA PLUMMER | | LABORER | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) | | 16b. SOCIAL SECURITY NO. | | 17. INFORMANT ADDRESS | |
| NO | | | | JULIA BRAXTON (MOTHER) same as #13 | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) | | | | | |
| PART I. DEATH WAS CAUSED BY: | | | | | |
| 2019 IMMEDIATE CAUSE (a) <u>Overwhelming sepsis</u> | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF | | | | | |
| (b) <u>pneumonia</u> | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF | | | | | |
| (c) <u>splenic artery, Hodgkins, Steroid Rx.</u> | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? | |
| | | | | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | |
| | | P.M. 19 | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | |
| | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>2/2</u> , 19 <u>82</u> , to <u>2/2</u> , 19 <u>82</u> , that (I) (we) lost saw the deceased alive on <u>2/2</u> , 19 <u>82</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) did (did not) view the body after death. | | | | | |
| 22b. SIGNATURE | | DEGREE | | 22c. DATE SIGNED | |
| <u>Mark A. Applier</u> | | MD | | 2/5/82 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) | | 22e. ADDRESS | | | |
| MARK APPLIER MD | | 201 E UNIVERSITY PKWY | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) | | 23b. DATE | | 23c. NAME OF CEMETERY OR CREMATORY | |
| BURIAL | | 2-9-82 | | ST. MARKS CEMETERY | |
| 24. FUNERAL DIRECTOR NAME | | 24b. ADDRESS | | 24c. DATE REC'D. BY REGISTRAR | |
| GEORGE R. SNOWDEN | | 246 N. WASHINGTON STREET ROCKVILLE, MD 20850 | | FEB 11 1982 | |
| 24d. REGISTRAR'S SIGNATURE | | 24e. REGISTRAR'S SIGNATURE | | | |
| | | | | | |

THOMAS D. WILSON

MEMORANDUM

OFFICE OF THE SECRETARY

WASHINGTON, D.C.

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death and may be retained by the hospital or attending physician.

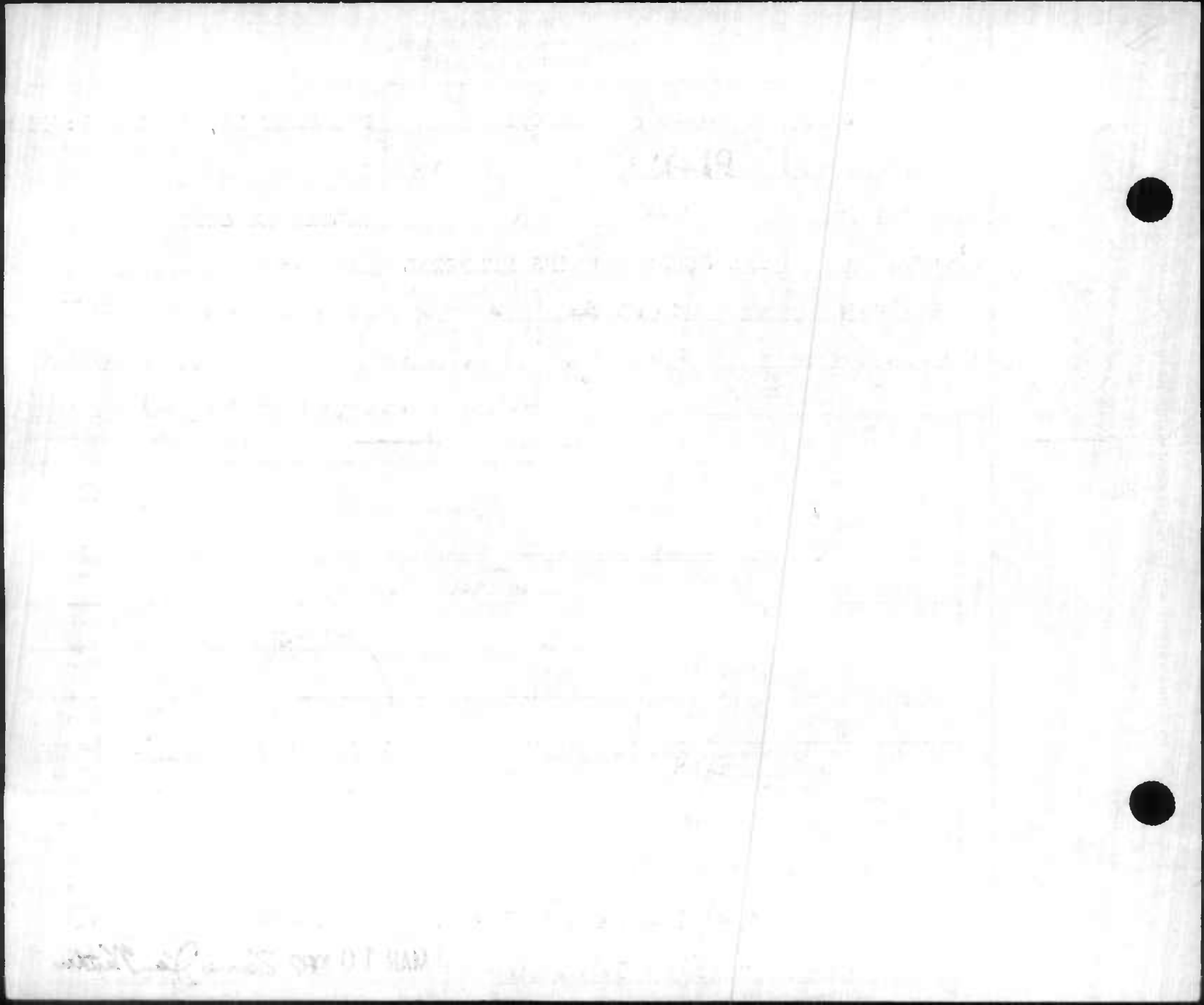
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or reinterment.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 2 0 3 3 / 8

| | | | |
|--|--|--|--|
| 1. FOR STATE REGISTRAR | | REG. NO. | |
| 1. DECEASED NAME (TYPE OR PRINT) | | 2a. DATE OF DEATH | |
| FIRST MIDDLE LAST
JOHN Sylvester BROOKS | | MONTH DAY YEAR
FEBRUARY 24, 1982 | |
| 3. SEX | | 2b. HOUR | |
| Male | | 11:45 PM | |
| 4. RACE | | 6. AGE (IN YEARS LAST BIRTHDAY) | |
| BLACK | | 83 | |
| 5. DATE OF BIRTH | | IF UNDER 1 YEAR | |
| MONTH DAY YEAR
12 11 98 | | MONTHS DAYS HOURS MIN. | |
| 7a. CITIZEN OF WHAT COUNTRY? | | 9. BALTIMORE CITY OR COUNTY OF DEATH | |
| USA | | BALTIMORE CITY MD. | |
| 7b. CITY OR TOWN OF DEATH | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | |
| Chas. Co. | | Driver | |
| 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) | | 12b. KIND OF BUSINESS OR INDUSTRY | |
| THE JOHNS HOPKINS HOSPITAL | | | |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) | | 13d. INSIDE CITY LIMITS? | |
| 13a. STATE | | YES <input checked="" type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| Maryland | | 13e. STREET ADDRESS | |
| 13b. COUNTY | | 2501 W. Hanvale ST | |
| 13c. CITY OR TOWN | | | |
| Baltimore | | | |
| 14. FATHER'S NAME | | 15. MOTHER'S MAIDEN NAME | |
| FIRST MIDDLE LAST
Dennis Brooks Harriett Maschett | | FIRST MIDDLE LAST | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) | | 17. INFORMANT | |
| (IF YES, GIVE WAR OR DATES) | | ADDRESS | |
| ? | | Helen Dorsey - 4120 Mount Inwood Rd. | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) | | | |
| PART 1. DEATH WAS CAUSED BY: | | | |
| IMMEDIATE CAUSE (a) <u>Cardiopulmonary arrest</u> | | | |
| 4275 | | | |
| DUE TO, OR AS A CONSEQUENCE OF | | | |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. | | | |
| (b) _____ | | | |
| DUE TO, OR AS A CONSEQUENCE OF | | | |
| (c) _____ | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) | | | |
| uremia secondary to acute renal failure | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | |
| | | | |
| 20a. AUTOPSY? | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? | |
| YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | |
| | | | |
| 21d. INJURY OCCURRED | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | |
| WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | |
| | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 2/24 1982, to 2/24 1982, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | |
| 22b. SIGNATURE | | 22c. DATE SIGNED | |
| Hugh Young Rienhoff Jr. | | 2/24/82 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) | | 22e. ADDRESS | |
| Hugh Young Rienhoff Jr. | | JHH | |
| 23a. BURIAL, CREMATION, REMOVAL (TYPE CITY) | | 23b. DATE | |
| Burial | | 3/4/82 | |
| 23c. NAME OF CEMETERY OR CREMATORY | | 23d. LOCATION CITY OR TOWN COUNTY STATE | |
| New Cathedral | | Balto Mel | |
| 24. FUNERAL DIRECTOR NAME | | 25a. DATE REC'D. BY REGISTRAR | |
| Chas H. Powell F/H - 31971 Schroeder St | | MAR 10 1982 | |
| 25b. REGISTRAR'S SIGNATURE | | | |
| | | | |



THIS IS A HOSPITAL OR ATTENDING PHYSICIAN. The law requires that the death certificate be executed within 24 hours after death. Pages may be required by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 22 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked on item 18 shows any injury, or other traumatic event, the medical examiner must be notified in case.

DHMH - 16 50M 1/81
(VRA 15, 4)

| STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH | | | | 8 2 0 3 5 7 9 | | | |
|---|--|---|--|---|--|--|--|
| FOR
1 - STATE REGISTRAR | | | | REG. NO. | | | |
| 1. DECEASED NAME
(TYPE OR PRINT)
FIRST MIDDLE LAST
ETHEL S BROWN | | | | 2a. DATE OF DEATH
MONTH DAY YEAR
2-1-82 | | | |
| 3. SEX
Female | | 4. RACE
BLACK | | 5. DATE OF BIRTH
MONTH DAY YEAR
10 5 41 | | 6. AGE (IN YEARS LAST BIRTHDAY)
40 YRS. MONTHS DAYS
IF UNDER 24 YRS. HOURS MIN. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
Maryland | | 7b. CITIZEN OF WHAT COUNTRY?
U. S. A. | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
Baltimore City, Maryland MD. | |
| 10. CITY OR TOWN OF DEATH
MD | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
UNIVERSITY Hospital | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
Homemaker | | 12b. KIND OF BUSINESS OR INDUSTRY
Home | |
| 13a. STATE
md | | 13b. COUNTY
BALTIMORE | | 13c. CITY OR TOWN
Baltimore | | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
CHARLES SCOTTON | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
BETRIE Banks | | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN) No | | | |
| 16b. SOCIAL SECURITY NO.
218-38-4053 | | 17. INFORMANT Baltimore ADDRESS Maryland 21216
Mr. Charles A. Brown 2410 Chelsea Terrace | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART 1. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Cardiopulmonary arrest
4300
DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b) Subarachnoid Hemorrhage
(c) Intracerebral Hematoma
DUE TO, OR AS A CONSEQUENCE OF | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: None | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) | | | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 1-31 , 19 82 , to 2-1 , 19 82 that (I) (we) lost saw the deceased alive on 2-1 , 19 82 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | |
| 22b. SIGNATURE
Louis W. Solomon MD | | | | DEGREE
MD | | 22c. DATE SIGNED
2.1.82 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
LOUIS SOLOMON MD | | | | 22e. ADDRESS
225. GREEN ST | | | |
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)
Burial | | 23b. DATE
2/5/82 | | 23c. NAME OF CEMETERY OR CREMATORY
Woodlawn Cemetery | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
Baltimore County, Md. | |
| 24. FUNERAL DIRECTOR
NAME BALTIMORE ADDRESS MARYLAND 21216
HERBERT E. NUTTER Funeral Home 3035 W. NORTH AVE | | | | 25a. DATE REC'D. BY REGISTRAR
FEB 3 1982 | | 25b. REGISTRAR'S SIGNATURE
James J. Martin | |

1509 BP

6204-68-313

3881 8 833

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. It may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours of death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

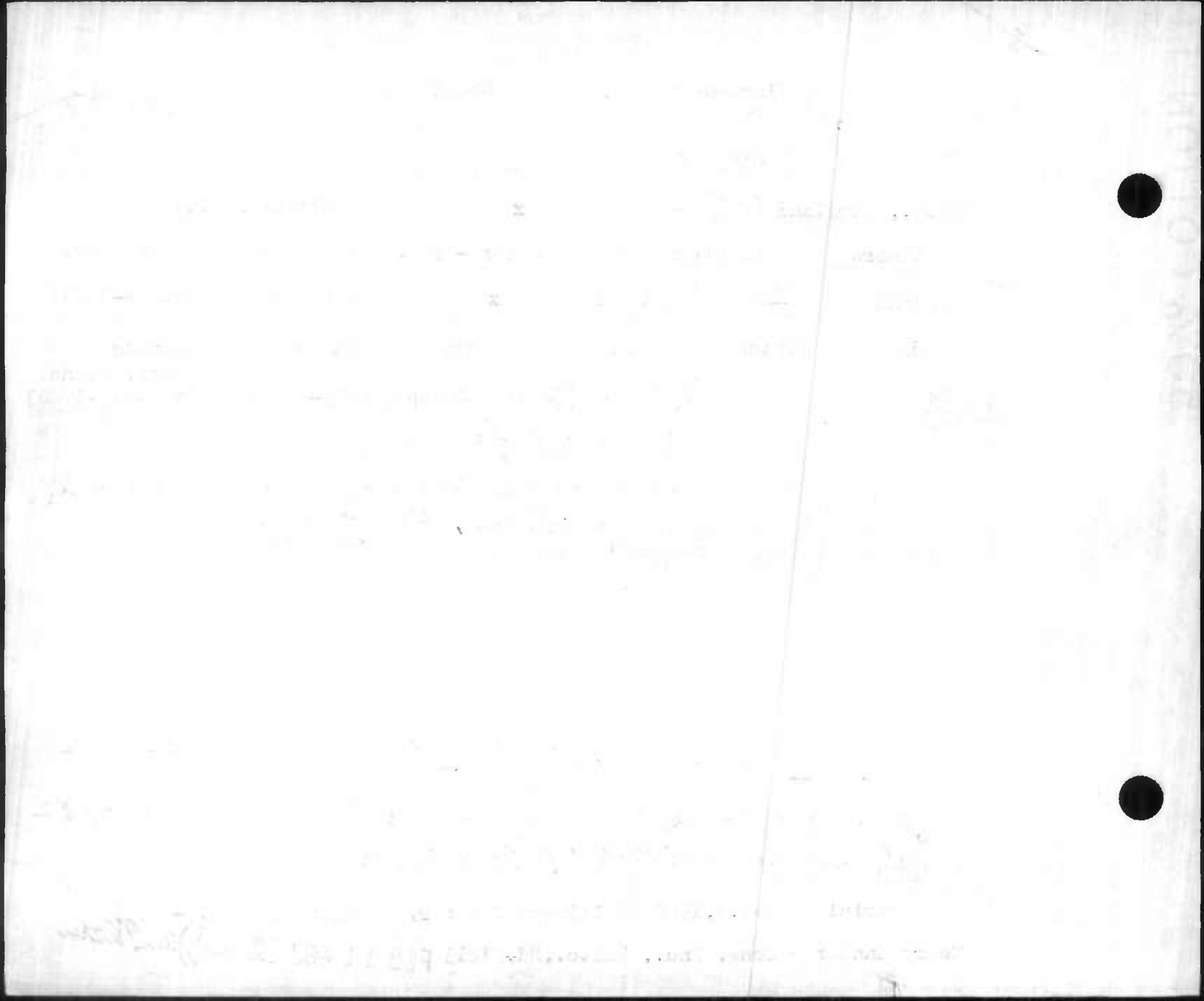
IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

1 - FOR
STATE
REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | |
|--|--|--|--|---|--|---|--|
| 1. DECEASED NAME
(Type or Print) Brown, Florence E. Brown | | | | 2a. DATE OF DEATH
MONTH DAY YEAR
2-6-82 | | 2b. HOUR
MIN.
3:40 PM | |
| 3. SEX
Female | | 4. RACE
White | | 5. DATE OF BIRTH
MONTH DAY YEAR
10 22 83 | | 6. AGE (IN YEARS LAST BIRTHDAY)
YRS. MONTHS DAYS
98 | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
Balto., Maryland | | 7b. CITIZEN OF WHAT COUNTRY?
USA | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
Baltimore City, MD. | |
| 10. CITY OR TOWN OF DEATH
Baltimore | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
Hamilton Nursing Center -21214 | | | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
Housewife | |
| 13a. STATE
Maryland | | 13b. COUNTY
-- | | 13c. CITY OR TOWN
Baltimore | | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
Ely Jeston Alban | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
Mary Catherine Merryman | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
No | | 16b. SOCIAL SECURITY NO.
(IF YES, GIVE WAR OR DATES)
212-74-9126 | | 17. INFORMANT
ADDRESS
York, Penna.
Chas. Joseph Kelly-559 Colonial Ave.-17403 | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART 1. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Renal failure
0539
Conditions, if any, which gave rise to immediate cause (b), stating the underlying cause lost.
(b) chronic urinary tract infection, Herpes Foster-
(c) revere
3 weeks | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:
19a. DATE OF OPERATION
19b. CONDITION FOR WHICH OPERATION WAS PERFORMED
20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | | | | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1b, PART 1 OR PART 2) | | | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | |
| 22a. I certify that (I) (the hospital) attended the deceased from 1/14 , 19 82 , to 2/6 , 19 82 , that (I) (we) lost saw the deceased alive on 2/6 , 19 82 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (do not) view the body after death. | | | | | | | |
| 22b. SIGNATURE
Fromm W. FROMM, MD | | | | DEGREE
MD | | 22c. DATE SIGNED
2/6/82 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
Fromm W. FROMM, MD | | | | 22e. ADDRESS
8014 Old Harford Rd., Baltimore | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)
Burial | | 23b. DATE
Feb. 9, 1982 | | 23c. NAME OF CEMETERY OR CREMATORY
Baltimore Cemetery | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
Baltimore, Md. - 21213 | |
| 24. FUNERAL DIRECTOR
Henry Sander & Sons, Inc., Balto., Md. - 21213 | | | | 25a. DATE REC'D. BY REGISTRAR
FEB 11 1982 | | | |

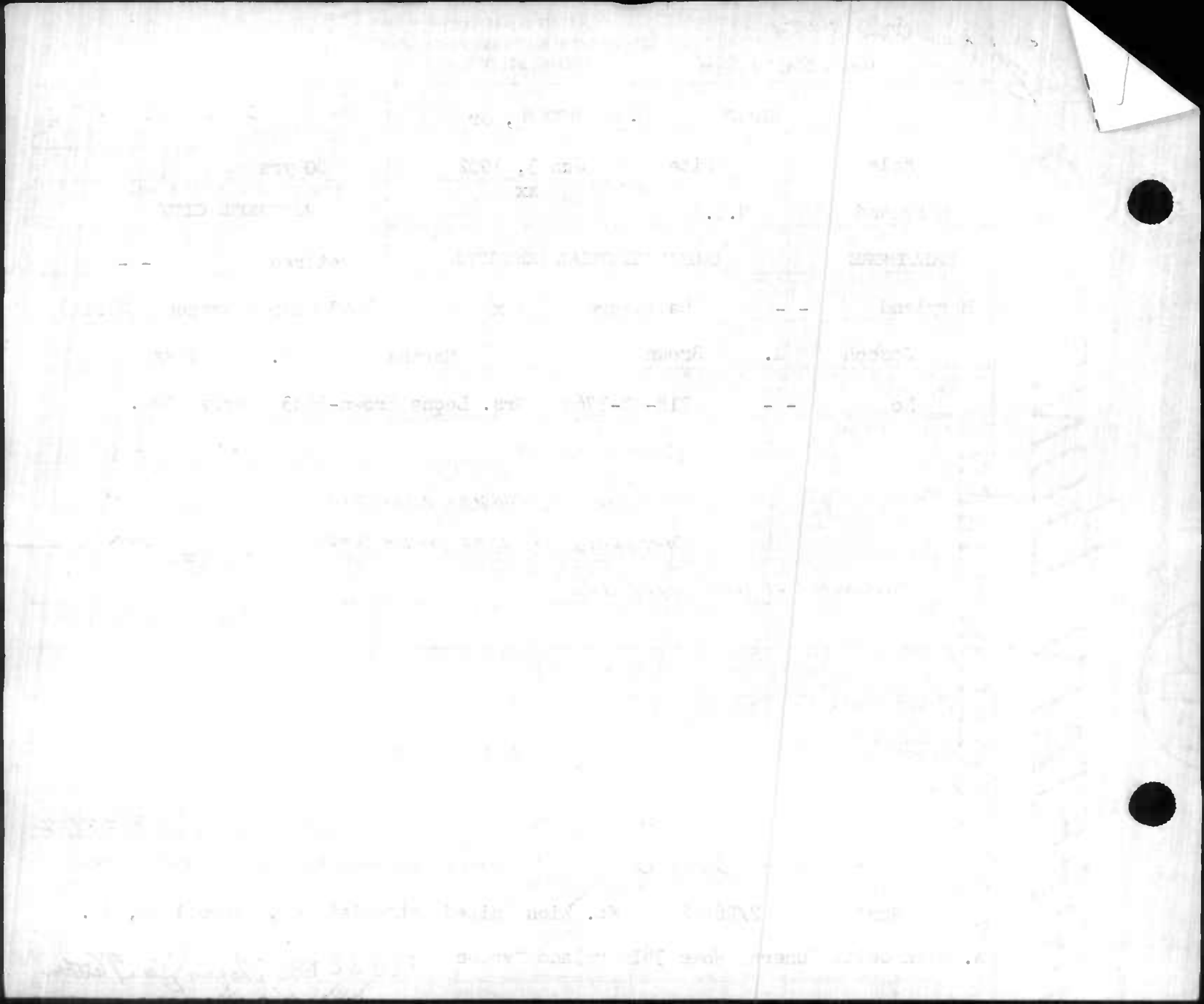


TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the funeral director with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

MEDICAL CERTIFICATION

| 1. DECEASED NAME (TYPE OR PRINT) | | | | 2a. DATE OF DEATH | | | | 2b. HOUR | | | |
|--|--------|--|--|--|-----|---|--|--|------|--|--|
| FIRST | MIDDLE | LAST | | MONTH | DAY | YEAR | | HOUR | MIN. | SEC. | |
| BROWN, Harry B. Sr | | | | 2 23 82 | | | | 8 14 AM | | | |
| 3. SEX | | 4. RACE | | 5. DATE OF BIRTH | | | | 6. AGE (IN YEARS LAST BIRTHDAY) | | | |
| Male | | White | | Jan 3, 1902 | | | | 80 yrs | | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) | | 7b. CITIZEN OF WHAT COUNTRY? | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | | | 9. BALTIMORE CITY OR COUNTY OF DEATH | | | |
| Maryland | | U.S.A. | | | | | | BALTIMORE CITY MD. | | | |
| 10. CITY OR TOWN OF DEATH | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | | | | 12b. KIND OF BUSINESS OR INDUSTRY | |
| BALTIMORE | | UNION MEMORIAL HOSPITAL | | | | Retired | | | | - | |
| 13a. STATE | | | | 13b. COUNTY | | 13c. CITY OR TOWN | | 13d. INSIDE CITY LIMITS? | | 13e. STREET ADDRESS | |
| Maryland | | | | - | | Baltimore | | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 3843 Quarry Avenue (21211) | |
| 14. FATHER'S NAME | | | | 15. MOTHER'S MAIDEN NAME | | | | | | | |
| Joseph R. Brown | | | | Martha E. Ness | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) | | 16b. SOCIAL SECURITY NO. | | 17. INFORMANT | | | | ADDRESS | | | |
| No | | 218-10-3767 | | Mrs. Leona Brown-3843 Quarry Ave. | | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| IMMEDIATE CAUSE (a) <u>CARDIAC ARREST</u> | | | | | | | | | | 7 hr. | |
| DUE TO, OR AS A CONSEQUENCE OF (b) <u>PROBABLE MYOCARDIAL INFARCTION</u> | | | | | | | | | | 7 wk. | |
| DUE TO, OR AS A CONSEQUENCE OF (c) <u>CARCINOMA OF LEFT UPPER LUNG</u> | | | | | | | | | | UNK | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: | | | | | | | | | | | |
| <u>CARCINOMA of LEFT UPPER LUNG</u> | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY? | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? | |
| | | | | | | | | YES <input type="checkbox"/> NO <input type="checkbox"/> | | YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | 21b. TIME OF INJURY | | | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | |
| | | | | HOUR A.M. MONTH DAY YEAR | | | | | | | |
| | | | | P.M. 19 | | | | | | | |
| 21d. INJURY OCCURRED | | | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | | | 21f. LOCATION | | | |
| WHITE <input type="checkbox"/> NOT WHITE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/> | | | | | | | | STREET CITY OR TOWN COUNTY STATE | | | |
| 22a. I certify that (I) (his) (her) attended the deceased from <u>2/21</u> 19 <u>82</u> , to <u>2/23</u> 19 <u>82</u> , that (I) (we) last saw the deceased alive on <u>2/23</u> 19 <u>82</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | | | |
| 22b. SIGNATURE | | | | | | | | DEGREE | | 22c. DATE SIGNED | |
| Frank R. Jackson | | | | | | | | MD | | 2/23/82 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) | | | | | | | | 22e. ADDRESS | | | |
| FRANK R. JACKSON | | | | | | | | UNION MEMORIAL Hosp. BALT. Md. | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) | | | | 23b. DATE | | 23c. NAME OF CEMETERY OR CREMATORY | | 23d. LOCATION | | | |
| Burial | | | | 2/26/82 | | Mt. Zion United Methodist Cem. | | Carroll Co, Md. STATE | | | |
| 24. FUNERAL DIRECTOR | | | | | | | | 25a. DATE REC'D. BY REGISTRAR | | 25b. REGISTRAR'S SIGNATURE | |
| A. Alan Seitz Funeral Home 3818 Roland Avenue | | | | | | | | FEB 26 1982 | | James J. W. W. W. | |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death and retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of cause.

FOR
1 - STATE
REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 2 0 3 5 8 2

REG. NO.

| | | | | | |
|---|--|---|---|--|--|
| 1. DECEASED NAME
(TYPE OR PRINT)
FIRST MIDDLE LAST
<u>Brown, Preston</u> | | | 2a. DATE OF DEATH
MONTH DAY YEAR
<u>2 4 82</u> | | 2b. HOUR
<u>11 AM</u> |
| 3. SEX
<u>Male</u> | 4. RACE
<u>Black</u> | 5. DATE OF BIRTH
MONTH DAY YEAR
<u>4 18 02</u> | | 6. AGE (IN YEARS LAST BIRTHDAY)
<u>79</u> YRS. | IF UNDER 1 YEAR
MONTHS DAYS HOURS MIN. |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
<u>La.</u> | 7b. CITIZEN OF WHAT COUNTRY?
<u>U.S.</u> | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
<u>Baltimore City</u> MD | |
| 10. CITY OR TOWN OF DEATH
<u>Baltimore</u> | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
<u>Sinai Hospital</u> | | 12a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)
13a. STATE <u>MD</u> 13b. COUNTY <u>Baltimore</u> 13c. CITY OR TOWN <u>Baltimore</u> 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 12b. KIND OF BUSINESS OR INDUSTRY
<u>Retired</u> |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
<u>Henry Brown</u> | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
<u>Julia Brown</u> | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
<u>NO</u> | 16b. SOCIAL SECURITY NO.
<u>225-01-7575</u> | 17. INFORMANT
ADDRESS <u>APT 801</u>
<u>Mrs. Louise Brown 717 Druid Park Lake</u> | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART 1. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>Myocardial infarction</u>
DUE TO, OR AS A CONSEQUENCE OF
(b) <u>bilateral pneumonia</u>
DUE TO, OR AS A CONSEQUENCE OF
(c) <u>4860</u>
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
<u>3 weeks</u>
<u>3 weeks</u> |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input type="checkbox"/> | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | |
| 21d. INJURY OCCURRED
WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>Jan 4</u> 19 <u>82</u> , to <u>Feb 4</u> 19 <u>82</u> , that (I) (we) last saw the deceased alive on <u>Feb 4</u> 19 <u>82</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | |
| 22b. SIGNATURE
<u>Lee Ann Roberts, M.D.</u> | | DEGREE | | 22c. DATE SIGNED
<u>2-4-82</u> | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
<u>Lee Ann Roberts</u> | | 22e. ADDRESS
<u>Sinai Hospital</u> | | | |
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)
<u>Burial</u> | 23b. DATE
<u>2-9-82</u> | 23c. NAME OF CEMETERY OR CREMATORY
<u>Balto. Cem.</u> | 23d. LOCATION
CITY OR TOWN COUNTY STATE
<u>Balto. Md.</u> | | |
| 24. FUNERAL DIRECTOR
NAME
<u>Joseph L. Russ</u> | | ADDRESS
<u>2222 W. North Ave.</u> | | 25a. DATE REC'D BY REGISTRAR
<u>FEB 9 1982</u> | 25b. REGISTRAR'S SIGNATURE
<u>James J. Nathan</u> |

Items #18a-22a Film G565 3/30/82 rSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

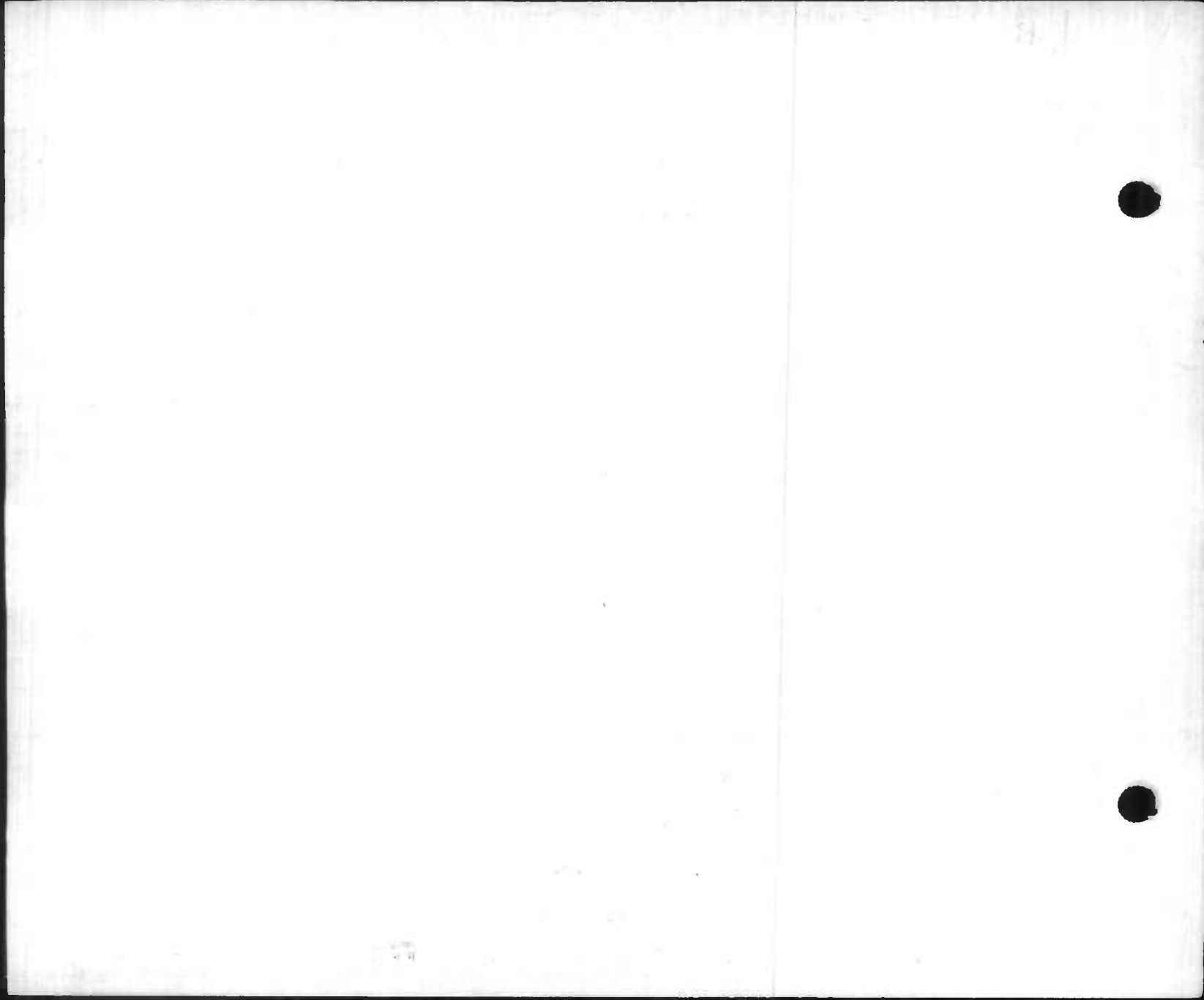
REG. NO.

| | | | | | | | | |
|--|---------|------------------|--|----------------|------------------------------------|---|---------------|--|
| 1. DECEASED NAME
(TYPE OR PRINT) | | | 2a. DATE KNOWN OF DEATH | | | 2b. HOUR | | |
| Wilbert J. Brown | | | 2. 10 19 82 | | | 2. 27 A. M. | | |
| 3. SEX | 4. RACE | 5. DATE OF BIRTH | 6. AGE (IN YEARS) | IF UNDER 1 YR. | IF UNDER 24 HRS. | 7c. DATE PRONOUNCED DEAD | 7d. HOUR | |
| Male | Black | 8 14 39 | 42 YRS. | | | 2 10 19 82 | 2. 27 A. M. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) | | | 7b. CITIZEN OF WHAT COUNTRY? | | | 9. BALTIMORE CITY OR COUNTY OF DEATH | | |
| MD | | | U.S.A. | | | Baltimore City, MD | | |
| 10. CITY OR TOWN OF DEATH | | | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | | |
| Baltimore | | | Provident Hospital | | | | | |
| 13a. STATE | | | 13b. COUNTY | | | 13c. CITY OR TOWN | | |
| MD | | | | | | Baltimore | | |
| 14. FATHER'S NAME | | | 15. MOTHER'S MAIDEN NAME | | | 16. SOCIAL SECURITY NO. | | |
| Wilbert Brown | | | Victoria Jones | | | 213-36-5926 | | |
| 17a. WAS DECEASED EVER IN U.S. ARMED FORCES? | | | 17b. INFORMANT | | | 17c. ADDRESS | | |
| No | | | Minnie & Wanda Brown | | | 2504 N. Guilford Avenue | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART I DEATH WAS CAUSED BY: | | | | | | | | |
| 7999 IMMEDIATE CAUSE (a) Undetermined | | | | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF | | | | | | | | |
| (b) | | | | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF | | | | | | | | |
| (c) | | | | | | | | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a). | | | | | | | | |
| 19a. DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | | | | 20. AUTOPSY? | |
| | | | | | | | YES XX NO | |
| 21a. EXTERNAL CAUSE WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH | | | 21b. TIME OF INJURY | | | 21c. HOW INJURY OCCURRED | | |
| | | | P.M. 19 | | | (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) | | |
| 21d. INJURY OCCURRED WHILE AT WORK NOT WHILE AT WORK | | | 21e. PLACE OF INJURY (AT HOME STREET, FACTORY, FARM, ETC.) | | | 21f. LOCATION | | |
| | | | | | | CITY OR TOWN COUNTY STATE | | |
| 22a. I certify that I took charge of the remains described above, held on Autopsy X, Inspection, Inquiry, and in my opinion death resulted from: Natural causes X, Accident, Suicide, Homicide, Undetermined manner. | | | | | | | | |
| ACTUAL SIGNATURE | | | TITLE (SPECIFY) | | | DATE SIGNED | | |
| Virginia L. Dolan | | | M.D. Assistant | | | 2-10-82 | | |
| EXAMINER'S NAME (TYPE OR PRINT) | | | ADDRESS | | | | | |
| Virginia L. Dolan, M.D. | | | 111 Penn Street | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) | | | 23b. DATE | | 23c. NAME OF CEMETERY OR CREMATORY | | 23d. LOCATION | |
| Burial | | | 2/16/82 | | Mt. Auburn Cemetery | | Baltimore MD | |
| 24. FUNERAL DIRECTOR | | | 25a. DATE REC'D. BY REGISTRAR | | | 25b. REGISTRAR'S SIGNATURE | | |
| Wm. C. March F/H, Inc. | | | 1101 E. North Ave. | | | FEB 11 1982 | | |

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, THE EXAMINER SHOULD EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR RECORDS. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

DHMH - 17
(VR A15 ME (5))
15M 2/80



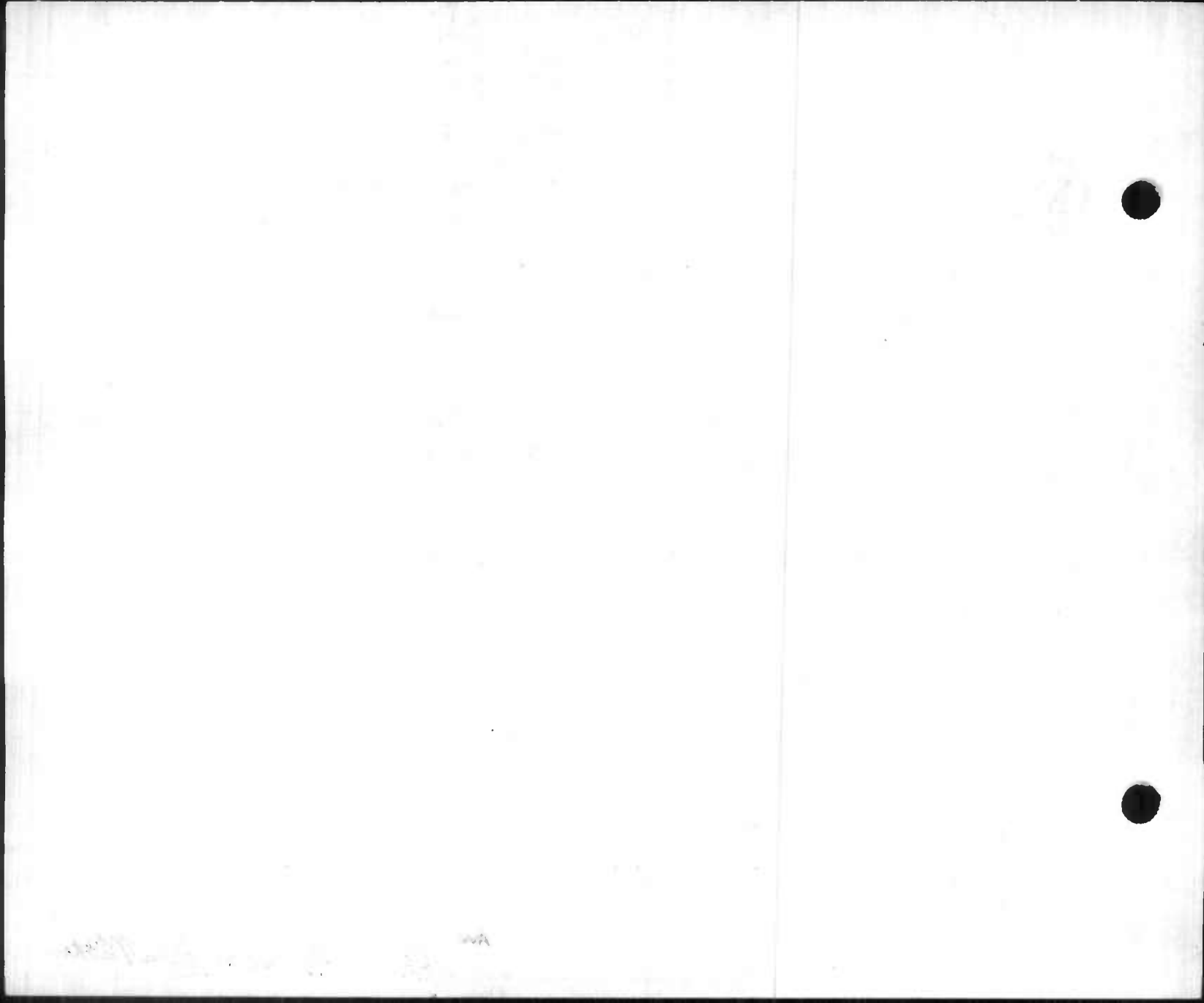
TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED IN THE DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

FOR
1- STATE
REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | | | | | | | | | | | |
|--|---------|------------------------------|---|---|-------------------|---------------------------------------|---|---|--------------------------------------|---|-----------------------------------|---|--|----------|--|----------|--|
| 1. DECEASED NAME
(TYPE OR PRINT) | | | FIRST MIDDLE LAST | | | 2a. DATE KNOWN OF DEATH | | | | MONTH DAY YEAR | | | | 2b. HOUR | | | |
| GILBERT | | | BROWNE | | | 2. DATE KNOWN OF DEATH ESTI. MATED | | | | 2 18 19 82 | | | | M | | | |
| 3. SEX | 4. RACE | 5. DATE OF BIRTH | | 6. AGE (IN YEARS LAST BIRTHDAY) | IF UNDER 1 YR. | IF UNDER 24 HRS. | | 7c. DATE PRONOUNCED DEAD | | | | MONTH DAY YEAR | | | | 2d. HOUR | |
| male | negro | 1 15 83 | | 79 YRS. | MONTHS | DAYS | HOURS | 2 18 19 82 | | | | 4:42 a m | | | | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) | | 7b. CITIZEN OF WHAT COUNTRY? | | | 8. MARRIED | | NEVER MARRIED | | 9. BALTIMORE CITY OR COUNTY OF DEATH | | | | | | | | |
| Md | | USA | | | WIDOWED | | DIVORCED | | Baltimore City MD. | | | | | | | | |
| 10. CITY OR TOWN OF DEATH | | | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | | | | 12b. KIND OF BUSINESS OR INDUSTRY | | | | | | |
| Baltimore | | | 2019 W. Lexington St. | | | | | | | | | | | | | | |
| 13a. STATE | | | 13b. COUNTY | | 13c. CITY OR TOWN | | 13d. INSIDE CITY LIMITS? | | 13e. STREET ADDRESS | | | | | | | | |
| Md | | | | | Baltimore | | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 2019 W. Lexington Street | | | | | | | | |
| 14. FATHER'S NAME | | | 15. MOTHER'S MAIDEN NAME | | | | | | | | | | | | | | |
| James | | | Brown | | | Emma | | | | | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) | | | 16b. SOCIAL SECURITY NO. | | | 17. INFORMANT ADDRESS | | | | | | | | | | | |
| No | | | 215-09-2670 | | | Marguerite L. Brown 2019 W. Lexington | | | | | | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I DEATH WAS CAUSED BY:
4029 IMMEDIATE CAUSE (a) <u>Hypertensive cardiovascular disease</u>
DUE TO, OR AS A CONSEQUENCE OF
(b) _____
DUE TO, OR AS A CONSEQUENCE OF
(c) _____
Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. | | | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | | | | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a. | | | | | | | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | | | | | | | | 20. AUTOPSY? | | | | | |
| | | | | | | | | | | | | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH | | | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) | | | | | | | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK | | | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) | | | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | | | | | | | |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> . | | | | | | | | | | | | | | | | | |
| ACTUAL SIGNATURE | | | | TITLE (SPECIFY) | | | | DATE SIGNED | | | | | | | | | |
| Ann M. Dixon, M.D. | | | | Assistant MEDICAL EXAMINER | | | | 2-18-82 | | | | | | | | | |
| EXAMINER'S NAME (TYPE OR PRINT) | | | | ADDRESS | | | | | | | | | | | | | |
| Ann M. Dixon, M.D. | | | | 111 Penn St. | | | | | | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) | | | | 23b. DATE | | 23c. NAME OF CEMETERY OR CREMATORY | | | | 23d. LOCATION CITY OR TOWN COUNTY STATE | | | | | | | |
| Burial | | | | 2/22/82 | | Mt Calvary Cemetery Anne Arundel Co | | | | Md | | | | | | | |
| 24. FUNERAL DIRECTOR NAME | | | | ADDRESS | | | | 25a. DATE REC'D. BY REGISTRAR | | | | 25b. REGISTRAR'S SIGNATURE | | | | | |
| William C. March | | | | F/H 1101 E. North Ave | | | | FEB 19 1982 | | | | James Van Natten | | | | | |



STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 2 0 3 5 8 5

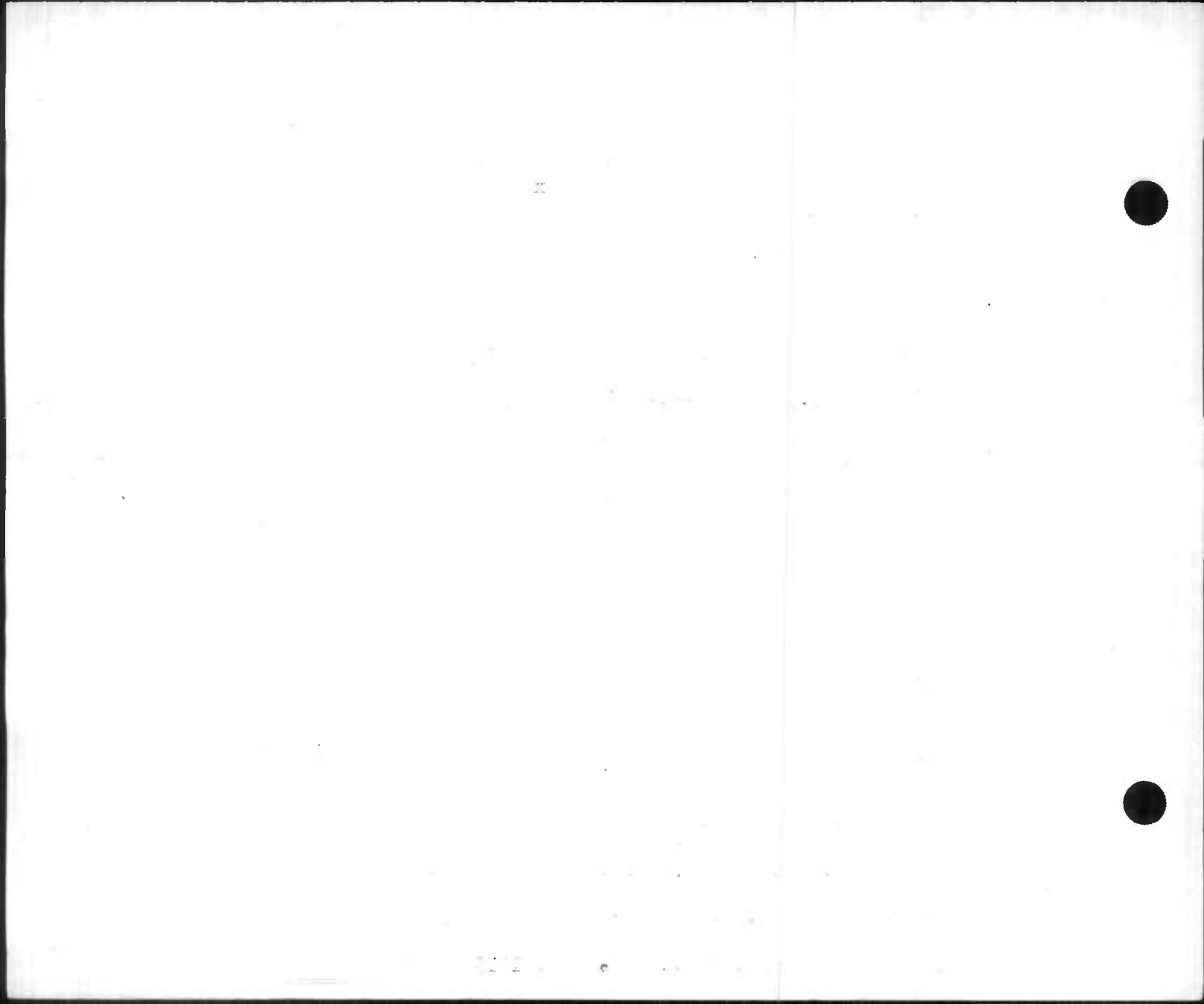
REG. NO.

| | | | | | |
|--|--|---|---|--|--|
| 1. FOR STATE REGISTRAR | | 2a. DATE OF DEATH | | 2b. HOUR | |
| 1. DECEASED NAME
(TYPE OR PRINT) | | 2a. DATE OF DEATH | | 2b. HOUR | |
| FIRST MIDDLE LAST
LeRoy Brundick | | MONTH DAY YEAR
February 20, 1982 | | 11 30 P.
M. | |
| 3. SEX | 4. RACE | 5. DATE OF BIRTH | 6. AGE (IN YEARS LAST BIRTHDAY) | 7. IF UNDER 1 YEAR | |
| Male | White | MONTH DAY YEAR
December 22, 1897 | 84 YRS. | MONTHS DAYS HOURS MIN. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) | 7b. CITIZEN OF WHAT COUNTRY? | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH | |
| Balto., Maryland | USA | | | Baltimore City, MD. | |
| 10. CITY OR TOWN OF DEATH | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | | 12b. KIND OF BUSINESS OR INDUSTRY |
| Baltimore | 303 Broadmoor Road - 21212 | | Engineer-U.S. Army | | Colonel, Retired |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) | 13b. COUNTY | 13c. CITY OR TOWN | 13d. INSIDE CITY LIMITS? | 13e. STREET ADDRESS | |
| Maryland | -- | Baltimore | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | 303 Broadmoor Road - 21212 | |
| 14. FATHER'S NAME | 15. MOTHER'S MAIDEN NAME | | | | |
| FIRST MIDDLE LAST
Frederick Brundick | FIRST MIDDLE LAST
Catherine Benson | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) | 16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) | 17. INFORMANT ADDRESS | | | |
| Yes | W.W. II 214-40-5611 | Mrs. Edith Wiest Brundick-303 Broadmoor Rd. | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1: DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) 4029 Cerebrovascular accident | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
Sudden |
| DUE TO, OR AS A CONSEQUENCE OF (b) Hypertension arteriosclerotic | | | | | Many years. |
| DUE TO, OR AS A CONSEQUENCE OF (c) Cardiovascular disease | | | | | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? | |
| | | | | YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | |
| 22a. I certify that (I) (the hospital) attended the deceased from 6-21 19 82, to 2 20 19 82, that (I) (we) lost saw the deceased alive on 6-21 19 82, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did not) view the body after death. | | | | | |
| 22b. SIGNATURE <i>Alfred G. Ossman, Jr., M.D.</i> DEGREE | | | | 22c. DATE SIGNED 2-22-82 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) Alfred G. Ossman, Jr., M.D. | | | | 22e. ADDRESS 1101 St. Paul Street - 21202 | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) | 23b. DATE | 23c. NAME OF CEMETERY OR CREMATORY | 23d. LOCATION CITY OR TOWN COUNTY STATE | | |
| Burial | Feb. 24, 1982 | Baltimore Cemetery | Baltimore, Md.-21213 | | |
| 24. FUNERAL DIRECTOR NAME | | 25a. DATE REC'D. BY REGISTRAR | | 25b. REGISTRAR'S SIGNATURE | |
| Henry Sander & Sons, Inc., Balto., Md. 21213 | | FEB 25 1982 | | <i>Frances Jean Parthen</i> | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified or one of the following must be notified.



STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 2 0 3 5 8 6

FOR
1 - STATE
REGISTRAR

REG. NO.

| | | | | | |
|---|------------------------------------|--|--|---|--|
| 1 DECEASED NAME
(TYPE OR PRINT)
HELEN
MIDDLE
Bryant
LAST | | | 2a. DATE OF DEATH
MONTH DAY YEAR
2/4/82
2b. HOUR
2:30 P.M. | | |
| 3. SEX
Female | 4 RACE
Black | 5. DATE OF BIRTH
MONTH DAY YEAR
9 5 25 | 6 AGE (IN YEARS LAST BIRTHDAY)
56 YRS. | | 7 UNDER 1 YEAR
IF UNDER 24 HRS.
MONTHS DAYS HOURS MIN. |
| 8. PLACE OF BIRTH (STATE OR FOREIGN)
NORTH CAROLINA | 7b. CITIZEN OF WHAT COUNTRY?
US | 9 BALTIMORE CITY OR COUNTY OF DEATH
Baltimore City, MD. | | 10 CITY OR TOWN OF DEATH
BALTO. | |
| 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
PROVIDENT HOSPITAL | | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE) | | 12b. KIND OF BUSINESS OR INDUSTRY |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)
13b. STATE
MARYLAND | | | 13c. CITY OR TOWN
BALTIMORE | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | 13e. STREET ADDRESS
637 N. CAREY ST. |
| 14. FATHER'S NAME
THURSTON
MIDDLE
LYNCH
LAST | | | 15. MOTHER'S MAIDEN NAME
NELLIE
MIDDLE
HOUSE
LAST | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
NO | | 16b. SOCIAL SECURITY NO. | | 17. INFORMANT
GLORIA MILLER
ADDRESS
637 N. CAREY ST. | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART 1. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>Cardiomyopathy Ament</u>
1749
DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last
(b) <u>Metastatic Disease</u>
DUE TO, OR AS A CONSEQUENCE OF
(c) <u>Carcinoma of Breast</u> | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
10 m.
6 months
12 weeks |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input type="checkbox"/> | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | |
| 21d. INJURY OCCURRED
WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>2/4/82</u> to <u>Feb 4</u> , 19 <u>82</u> , that (I) (we) last saw the deceased alive on <u>2/4</u> , 19 <u>82</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | |
| 22b. SIGNATURE
<u>A. Miranda</u> | | DEGREE
ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> | | 22c. DATE SIGNED | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
A. MIRANDA | | 22e. ADDRESS
PROVIDENT HOSP. | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)
BURIAL | | 23b. DATE
2-9-82 | 23c. NAME OF CEMETERY OR CREMATORY
WOODLAWN CEMT. | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
BALTIMORE, MARYLAND |
| 24. FUNERAL DIRECTOR
NAME
ELIZABETH L. PHILLIPS
ADDRESS
1721 N. MONROE ST. | | | 25a. DATE REC'D. BY REGISTRAR
FEB 10 1982 | | |

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. GIVE PAGE 4 TO THE CHIEF MEDICAL EXAMINER, ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

1- FOR
STATE
REGISTRAR

| | | | | | | | | |
|--|------------------|---|---|---|------------------|---|------------------------|--|
| 1. DECEASED NAME
(TYPE OR PRINT)
Harry BRZOSKOWSKI (Broscoe) | | | 2a. DATE KNOWN OF DEATH
ESTIMATED
2 21 1982 | | | 2b. DATE OF DEATH
MONTH DAY YEAR
2 21 1982 | | |
| 3. SEX
Male | 4. RACE
White | 5. DATE OF BIRTH
MONTH DAY YEAR
9 23 1920 | 6. AGE (IN YEARS)
LAST BIRTHDAY
64 YRS. | IF UNDER 1 YR.
MONTHS DAYS HOURS MIN. | IF UNDER 24 HRS. | 7c. DATE PRONOUNCED DEAD
MONTH DAY YEAR
2 21 1982 | 7d. HOUR
11:23 P.M. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
MD. | | 7b. CITIZEN OF WHAT COUNTRY?
USA | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
Baltimore City, MD. | | |
| 10. CITY OR TOWN OF DEATH
Baltimore | | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
Baltimore City Hospital | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)
PRINTER | | |
| 12b. KIND OF BUSINESS OR INDUSTRY | | | | | | | | |
| USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) | | | | | | | | |
| 13a. STATE
MD | | 13b. COUNTY | | 13c. CITY OR TOWN
BALTO | | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | |
| 13e. STREET ADDRESS
4 N. CLINTON ST. | | | | | | | | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
FELIX BRZOSKOWSKI | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
CORDULA TROKA | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
NO | | 16b. SOCIAL SECURITY NO.
(IF YES, GIVE WAR OR DATES)
212-03-8756 | | 17. INFORMANT
ADDRESS
4 N. CLINTON ST.
CARIS SCHAUBLE | | | | |

| | | |
|--|--|--|
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I DEATH WAS CAUSED BY:
4292 IMMEDIATE CAUSE (a) <u>Arteriosclerotic cardiovascular disease</u>
Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last:
(b) _____
(c) _____ | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
|--|--|--|

PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).

| | | | | | |
|--|--|---|--|---|--|
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | | 20. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2) | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | |

| | | | | | |
|--|--|--|--|------------------------|--|
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> . | | | | | |
| ACTUAL SIGNATURE
Hormez R. Guard | | TITLE (SPECIFY)
M.D. Assistant MEDICAL EXAMINER | | DATE SIGNED
2/22/82 | |
| EXAMINER'S NAME
(TYPE OR PRINT)
Hormez R. Guard, M.D. | | ADDRESS
111 Penn St. Balto., MD. | | | |

| | | | | | | | |
|---|--|---------------------|--|---|--|--|--|
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)
BURIAL | | 23b. DATE
3-1-82 | | 23c. NAME OF CEMETERY OR CREMATORY
OAKLAWN CEM | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
BALTO MD | |
| 24. FUNERAL DIRECTOR
NAME ADDRESS
JOHN M. WEBER & SONS INC 401 S. CHESTER | | | | 25a. DATE REC'D BY REGISTRAR
FEB 24 1982 | | 25b. REGISTRAR'S SIGNATURE
Hormez R. Guard | |

2610 BP

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours of death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of same.

1. FOR
STATE
REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

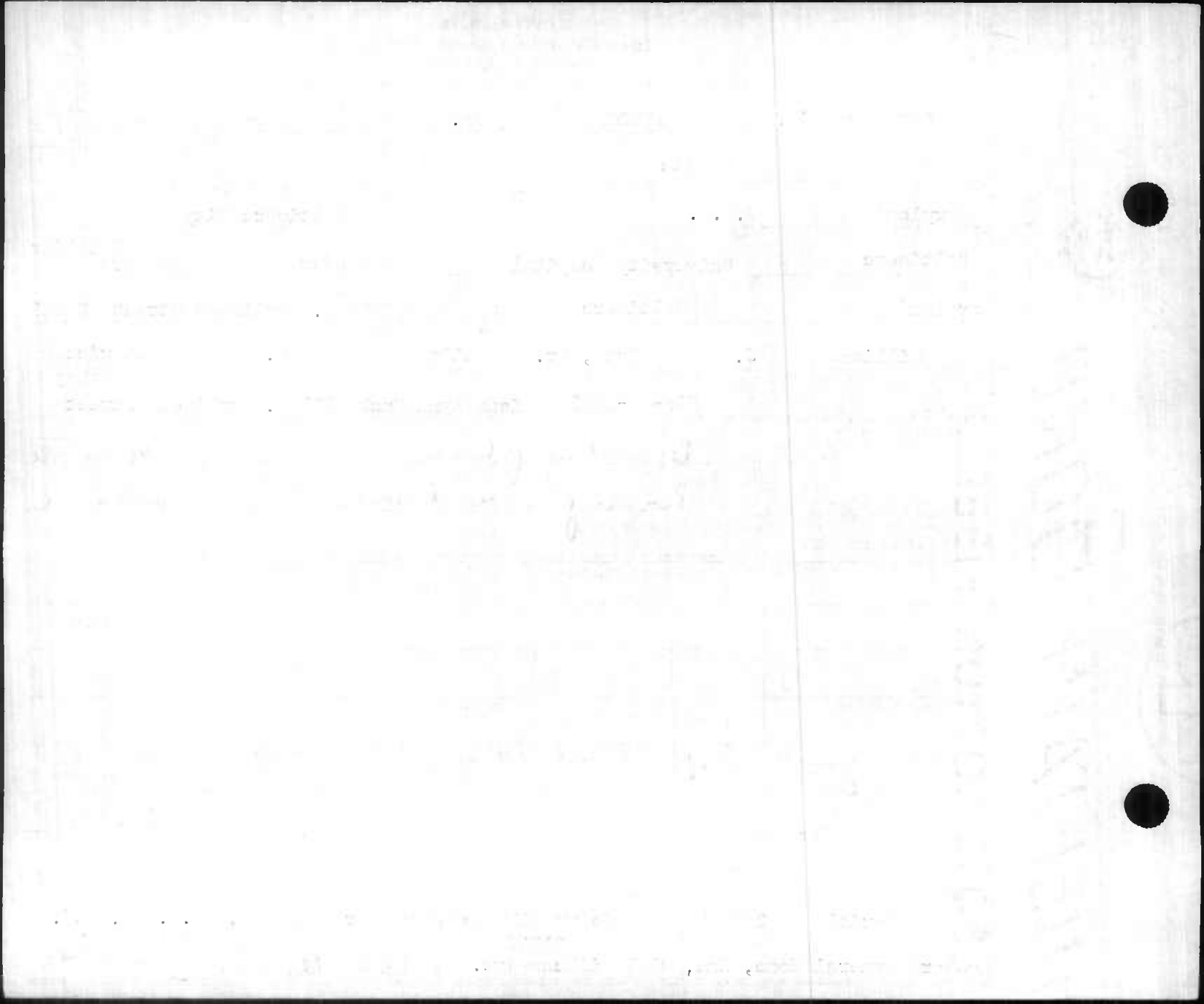
REG. NO.

| | | | | | | | | | |
|--|--|---|---|---|--|--|---|--|--|
| 1. DECEASED NAME
(TYPE OR PRINT)
FIRST MIDDLE LAST
CHRISTINA BUCCHER | | | 2a. DATE OF DEATH
MONTH DAY YEAR
2 27 82 | | | 2b. HOUR
11:22^A | | | |
| 3. SEX
F | | 4. RACE
W | | 5. DATE OF BIRTH
MONTH DAY YEAR
12 28 81 | | 6. AGE (IN YEARS LAST BIRTHDAY)
YRS. MONTHS DAYS
2 2 | | IF UNDER 1 YEAR
IF UNDER 24 HRS
HOURS MIN. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
MD | | 7b. CITIZEN OF WHAT COUNTRY?
USA | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
BALT City MD. | | | |
| 10. CITY OR TOWN OF DEATH
BALT | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
BCH | | | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
Infant | | 12b. KIND OF BUSINESS OR INDUSTRY | |
| 13a. STATE
MD | | | 13b. COUNTY
BALT | | 13c. CITY OR TOWN
BALT | | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
MICHAEL BUCHER | | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
CHRISTINA DAVELLA | | | 13e. STREET ADDRESS
1222 STEELTON 21224 | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN) | | 16b. SOCIAL SECURITY NO.
- | | 17. INFORMANT
ADDRESS
Mr. & Mrs. Michael Buccheri 1222 Steelton Ave | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:
7798 IMMEDIATE CAUSE (a) CARDIAC ARREST
DUE TO, OR AS A CONSEQUENCE OF
(b) UNKNOWN
DUE TO, OR AS A CONSEQUENCE OF
(c) _____
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) | | | | | | | | | |
| 19a. DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK | | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 2/27 19 82 , to 2/27 19 82 , that (I) (we) last saw the deceased alive on 2/27 19 82 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death. | | | | | | | | | |
| 22b. SIGNATURE
B Straus MD | | | | | | DEGREE
MD | | 22c. DATE SIGNED
2/27/82 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
B STRAUS, MD | | | | | | 22e. ADDRESS
BALTIMORE CITY HOSP | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)
Burial | | | 23b. DATE
3/2/82 | | 23c. NAME OF CEMETERY OR CREMATORY
Oaklawn Cemetery | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
Baltimore Maryland | | |
| 24. FUNERAL DIRECTOR
NAME
Zannino Funeral Home, 263 S. Conkling St. | | | | | | 25a. DATE REC'D. BY REGISTRAR (25b. REGISTRAR'S SIGNATURE)
MAR 3 1982 <i>Francis J. Nathan</i> | | | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH | | | | | | | | | | REG. NO. | |
|---|--|---|--|---|--|---|--|--|--|----------|--|
| 1. DECEASED NAME
(TYPE OR PRINT)
FIRST MIDDLE LAST
ROBERT KENNETH BUCK, SR. | | | | | | 2a. DATE OF DEATH
MONTH DAY YEAR
2 4 82 | | 2b. HOUR
8²⁰ P.M. | | | |
| 3. SEX
Male | | 4. RACE
White | | 5. DATE OF BIRTH
MONTH DAY YEAR
5 29 47 | | 6. AGE (IN YEARS LAST BIRTHDAY)
34 YRS. | | 8. IF UNDER 1 YEAR
MONTHS DAYS HOURS MIN.
0 0 0 0 | | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
Maryland | | 7b. CITIZEN OF WHAT COUNTRY?
U.S.A. | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
Baltimore City MD. | | | | | |
| 10. CITY OR TOWN OF DEATH
Baltimore | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
University Hospital | | | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
Roofer | | 12b. KIND OF BUSINESS OR INDUSTRY
Phillips Roofers | | | |
| 13a. STATE
Maryland | | 13b. COUNTY | | 13c. CITY OR TOWN
Baltimore | | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS
321 S. Smallwood Street 21223 | | | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
William J. Buck, Sr. | | | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
Ella M. DuBritton | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
NO | | 16b. SOCIAL SECURITY NO.
(IF YES, GIVE WAR OR DATES)
218-48-0093 | | 17. INFORMANT
Diana Lynn Buck | | ADDRESS
321 S. Smallwood Street 21223 | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART 1. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Respiratory failure
5739
DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b) Probably liver disease
DUE TO, OR AS A CONSEQUENCE OF
(c)
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
40 minute
unknown | | | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | | | | | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | | | | | |
| 22a. I certify that (1) (this hospital) attended the deceased from 2/4/82 to 2/4/82 , that (1) (we) lost
saw the deceased alive on 2/4/82 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated
above, (1) (we) (did) not view the body after death. | | | | | | | | | | | |
| 22b. SIGNATURE
So, [Signature] | | | | DEGREE
MD | | | | 22c. DATE SIGNED
2/4/82 | | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
So | | | | 22e. ADDRESS
22 S Green St. Balto, Md. 21201 | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)
Burial | | 23b. DATE
2/8/82 | | 23c. NAME OF CEMETERY OR CREMATORY
Cedar Hill Cemetery | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
Brooklyn Pk. A.A. Co. Md. | | | | | |
| 24. FUNERAL DIRECTOR
NAME ADDRESS
Hubbard Funeral Home, Inc. 4107 Wilkens Ave. 21229 | | | | 25a. DATE REC'D. BY REGISTRAR
FEB 8 1982 | | 25b. REGISTRAR'S SIGNATURE
Frances Jan Neithen | | | | | |

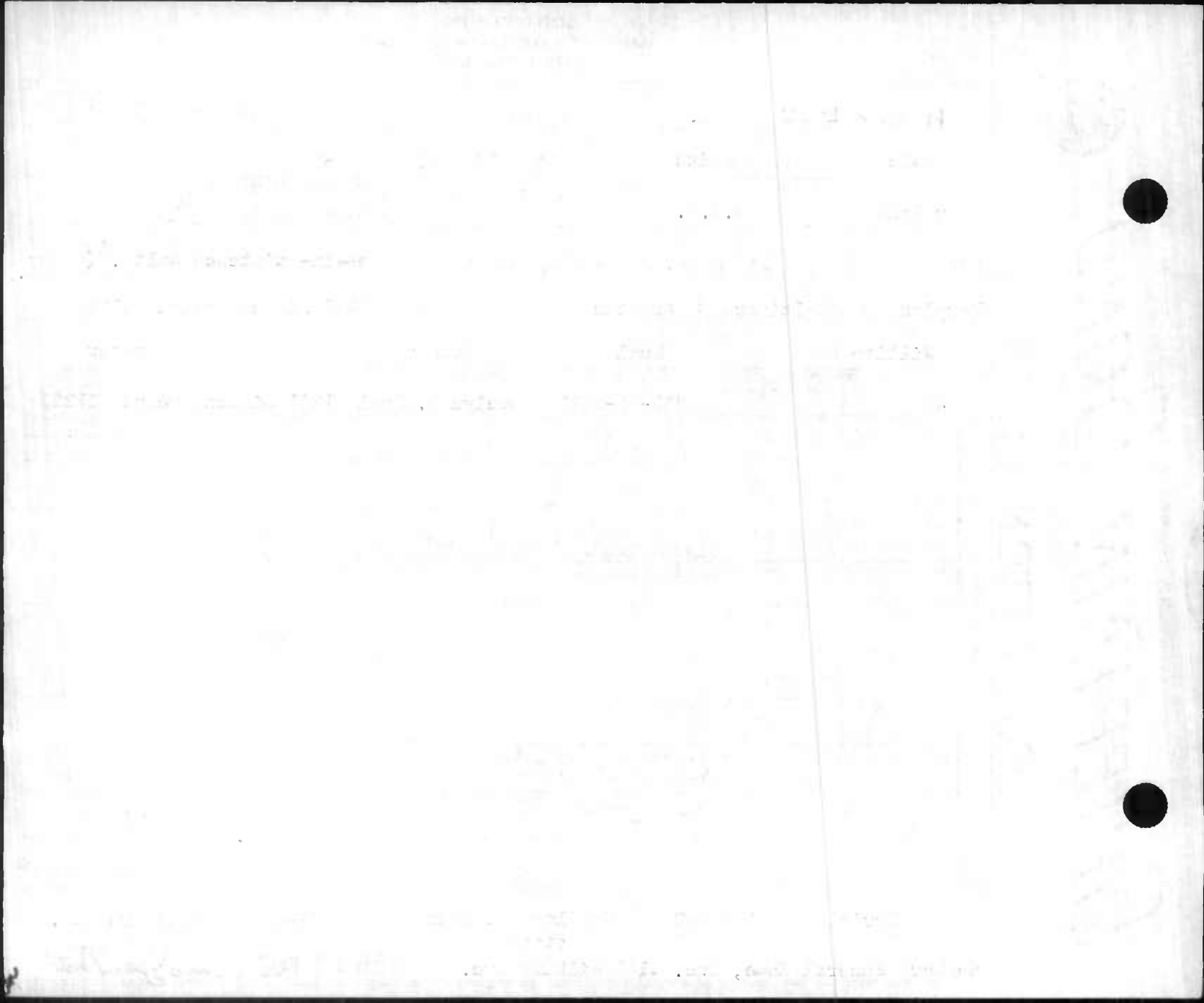


TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be filed within 72 hours after death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH | | | | | | | | | | REG. NO. | |
|--|--|---|--|---|--|---|--|---|--|--|--|
| 1. DECEASED NAME
(TYPE OR FIRST MIDDLE LAST)
ALBERT G. BUHL | | | | | | 2a. DATE OF DEATH
MONTH DAY YEAR
2-8-82 | | | | 2b. HOUR
3:50 A.M. | |
| 3. SEX
Male | | 4. RACE
White | | 5. DATE OF BIRTH
MONTH DAY YEAR
12 16 99 | | 6. AGE (IN YEARS LAST BIRTHDAY)
82 | | IF UNDER 1 YEAR
MONTHS DAYS | | IF UNDER 24 HRS.
HOURS MIN. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
Maryland | | 7b. CITIZEN OF WHAT COUNTRY?
U.S.A. | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
Baltimore City MD. | | | | | |
| 10. CITY OR TOWN OF DEATH
Baltimore | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
St. Agnes Hospital | | | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
Repair-Maintenance | | 12b. KIND OF BUSINESS OR INDUSTRY
City of Balto. (Water Dept.) | | | |
| 13a. STATE
Maryland | | 13b. COUNTY
Baltimore | | 13c. CITY OR TOWN
Arbutus | | 13d. INSIDE CITY LIMITS?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 13e. STREET ADDRESS
1241 Linden Avenue 21227 | | | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
William Buhl | | | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
Amanda Hubbert | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
NO | | 16b. SOCIAL SECURITY NO.
217-22-8873 | | 17. INFORMANT
Evelyn D. Buhl | | ADDRESS
1241 Linden Avenue 21227 | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART 1. DEATH WAS CAUSED BY:
1539 IMMEDIATE CAUSE (a) Hypertension leading to aneurysm
DUE TO, OR AS A CONSEQUENCE OF
(b) Septic
DUE TO, OR AS A CONSEQUENCE OF
(c) Disseminated CA of colon. | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | | | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> AT WORK
AT HOME <input type="checkbox"/> AT WORK | | | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 1/8/82 to 1/8/82, that (I) (we) lost the deceased alive on 1/8/82, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | | | |
| 22b. SIGNATURE
Paul Kordyansky M.D. | | | | | | DEGREE | | ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | 22c. DATE SIGNED
2/8/82 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) | | | | | | 22e. ADDRESS
900 S. Caton Ave. Balto. Md. 21229 | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)
Burial | | | | 23b. DATE
2/11/82 | | 23c. NAME OF CEMETERY OR CREMATORY
Woodlawn Cemetery | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
Woodlawn Baltimore Md. | | | |
| 24. FUNERAL DIRECTOR
NAME
Hubbard Funeral Home, Inc. | | | | | | ADDRESS
4107 Wilkens Ave. | | 25a. DATE REC'D. BY REGISTRAR
FEB 11 1982 | | 25b. REGISTRAR'S SIGNATURE
James J. Keith | |



STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 2 0 3 5 9 1

FOR
STATE
REGISTRAR

REG. NO.

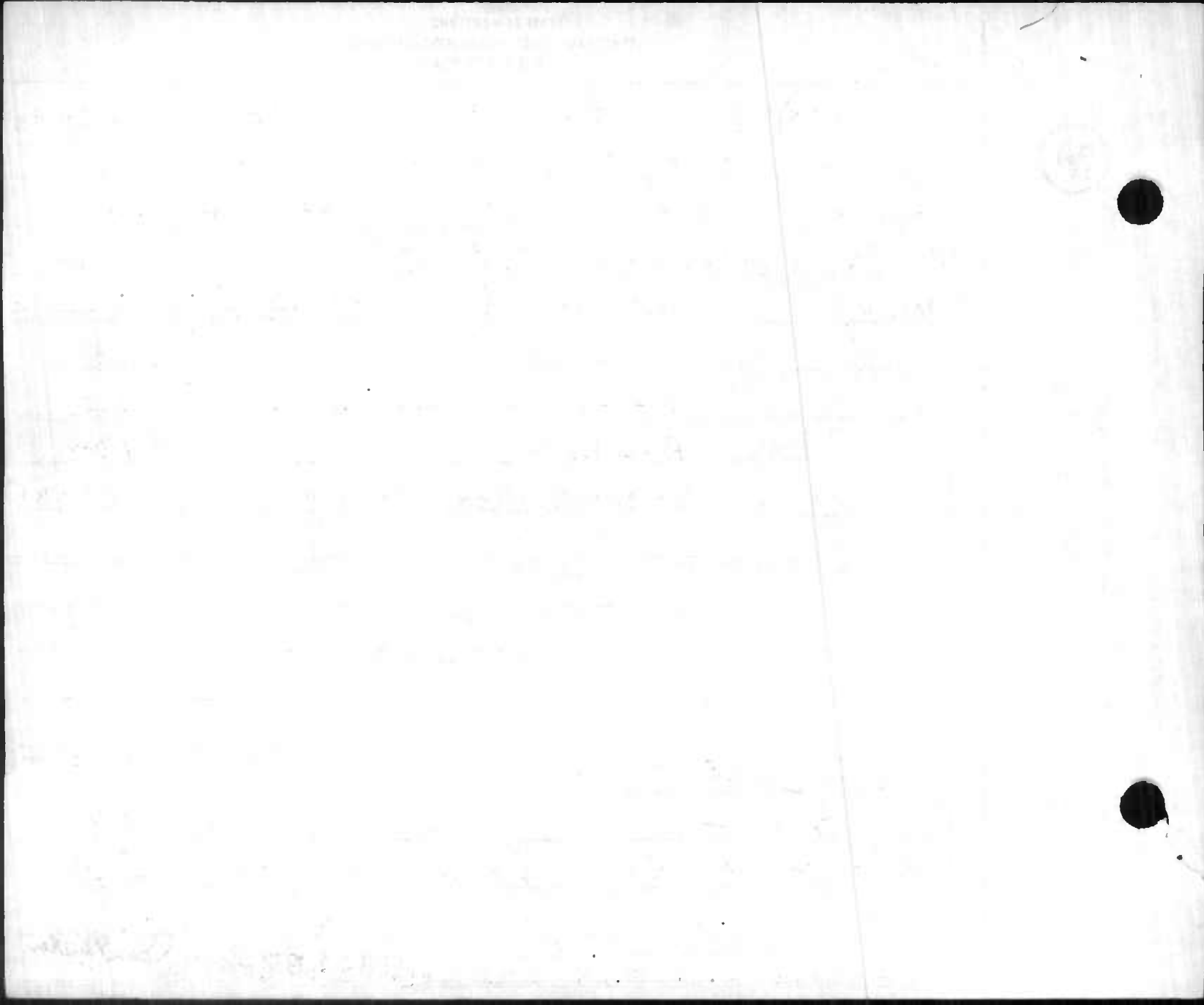
| | | | | | |
|---|---|---|---|--|--|
| 1. DECEASED NAME
(TYPE OR PRINT) (AKA MARY FRANCES BUNCH MARY FRANCES BUNCH) | | 2a. DATE OF DEATH
MONTH DAY YEAR
FEBRUARY 10, 1982 | | 2b. HOUR
8:10P ^M | |
| 3. SEX
Female | 4. RACE
White | 5. DATE OF BIRTH
MONTH DAY YEAR
Dec. 5 1912 | | 6. AGE (IN YEARS LAST BIRTHDAY)
69 YRS | |
| 7a. BIRTHPLACE
(STATE OR FOREIGN COUNTRY)
Md. | 7b. CITIZEN OF WHAT COUNTRY?
U.S.A. | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
BALTIMORE CITY MD. | |
| 10. CITY OR TOWN OF DEATH
Baltimore | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
JOHNS HOPKINS HOSPITAL | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
Homemaker | | 12b. KIND OF BUSINESS OR INDUSTRY
- |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) | | | | | |
| 13a. STATE
Md. | 13b. COUNTY
- | 13c. CITY OR TOWN
Baltimore | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | 13e. STREET ADDRESS
5740 Cedonia Ave. | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
Henry Luft | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
Alice West | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO, OR UNKNOWN) (IF YES, GIVE WAR OR DATES)
no | | 16b. SOCIAL SECURITY NO.
214-14-3991 | | 17. INFORMANT ADDRESS
Michael Bunch (son) same address | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>RESPIRATORY ARREST</u>
<u>1830</u>
DUE TO, OR AS A CONSEQUENCE OF
(b) <u>OVARIAN CANCER</u>
DUE TO, OR AS A CONSEQUENCE OF
(c) _____
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input type="checkbox"/> | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) | |
| 21d. INJURY OCCURRED
WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>1-31-82</u> 19 <u>82</u> to <u>2-10</u> 19 <u>82</u> , that (I) (we) lost saw the deceased alive on <u>19</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | |
| 22b. SIGNATURE
<u>F. Abrams</u> | | DEGREE
ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> | | 22c. DATE SIGNED
<u>2-10-82</u> | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
<u>F. ABRAMS</u> | | 22e. ADDRESS
<u>601 North Broadway</u> | | | |
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)
Burial | | 23b. DATE
2/13/82 | | 23c. NAME OF CEMETERY OR CREMATORY
Gardens of Faith | |
| 23d. LOCATION
CITY OR TOWN COUNTY STATE
Balto. Md. | | 23e. DATE REC'D. BY REGISTRAR
FEB 16 1982 | | | |
| 24. FUNERAL DIRECTOR
NAME
Schimunek Funeral Home, Inc.
3331 Brehms Lane, Balto. Md. 21213 | | 25. REGISTRAR'S SIGNATURE
<u>James J. Nathan</u> | | | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed in the office of death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

11-12-1988



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon copies. Pages 1 and 2 should be filled with information after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

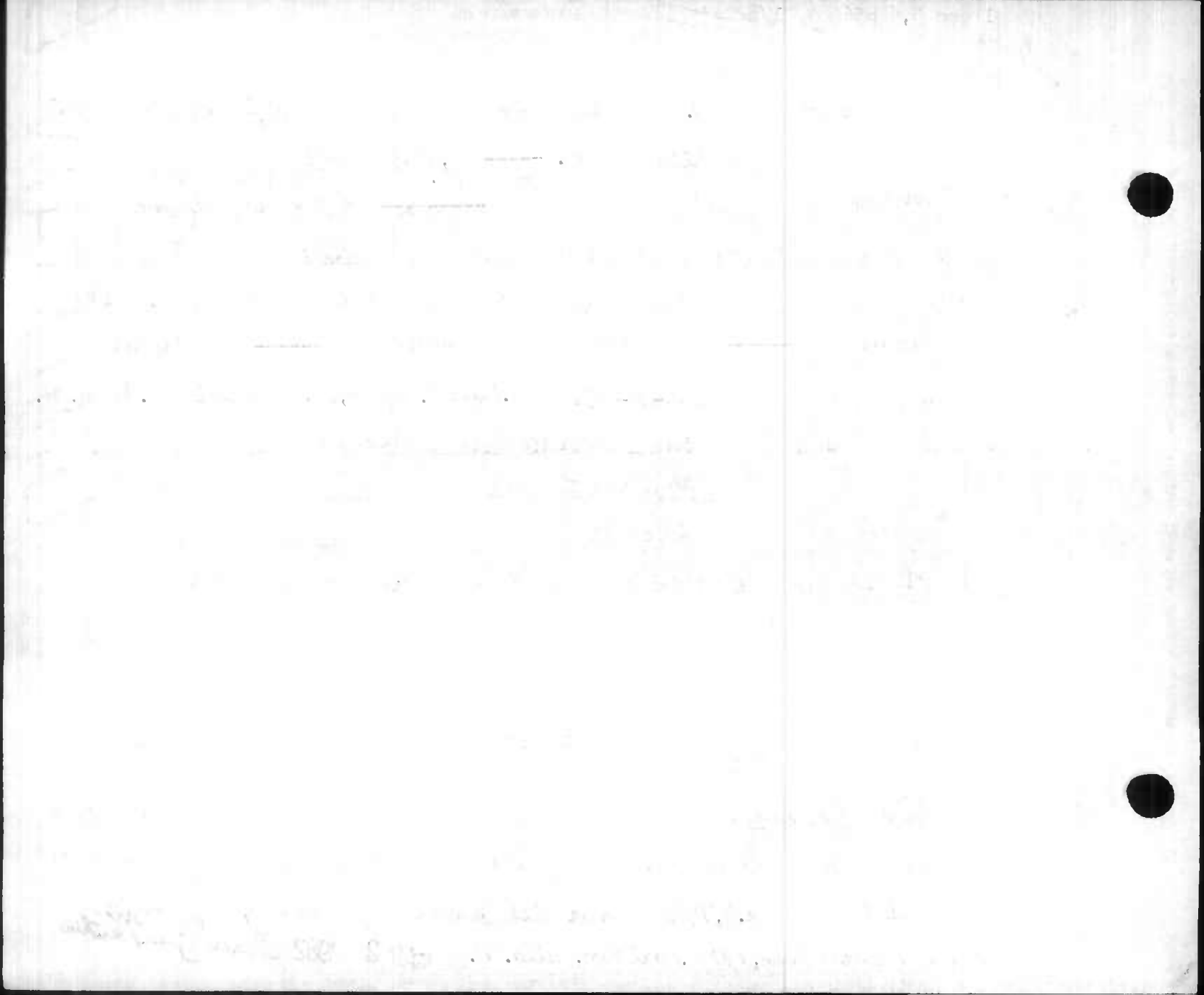
Item 5,06566 4/21/82 gj

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 2 0 3 5 9 3

REG. NO.

| | | | | | | | | | |
|--|--|--|--|---|--|---|--|--|--|
| 1. DECEASED NAME
(TYPE OR PRINT) ALLENA B. BURKEY | | | 2a. DATE OF DEATH
MONTH DAY YEAR
02-28-82 | | | 2b. HOUR
8:55 P.M. | | | |
| 3. SEX
Female | | 4. RACE
White | | 5. DATE OF BIRTH
MONTH DAY YEAR
Aug. 30, 1933 | | 6. AGE (IN YEARS LAST BIRTHDAY)
48 | | 7. IF UNDER 1 YEAR
MONTHS DAYS HOURS MIN.
YRS. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
Tennessee | | 7b. CITIZEN OF WHAT COUNTRY?
USA | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
CITY of Baltimore MD. | | | |
| 10. CITY OR TOWN OF DEATH
BALTIMORE | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
SOUTH BALT. GEN HOSP | | | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
Housewife | | 12b. KIND OF BUSINESS OR INDUSTRY | |
| 13a. STATE
MD | | 13b. COUNTY | | 13c. CITY OR TOWN
BALTIMORE | | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS
1306 S. HANOVER ST. | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
Victor ----- Banner | | | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
Lockie ----- Tipton | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)
No | | | | 16b. SOCIAL SECURITY NO.
216-28-7871 | | 17. INFORMANT
ADDRESS
Mr. Leon P. Burkey, 2810 Mountain Rd. Joppa, Md. | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART 1. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) CARDIOPULMONARY ARREST
4100
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b) PROBABLE MI
(c) ASCVD | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)
① LUNG CANCER - S/P ① LUNG RESECTION | | | | | | | | | |
| 19a. DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | |
| 21d. INJURY OCCURRED
WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 2/28 19 82 , to 2/28 19 82 , that (I) (we) lost 2/28 19 82 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death. | | | | | | | | | |
| 22b. SIGNATURE
Alex Rosenko | | | | | | DEGREE
ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> | | 22c. DATE SIGNED
2/28/82 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
ALEXANDER KOSENKO | | | | | | 22e. ADDRESS
3001 S. HANOVER ST. 21230 | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)
Burial | | | 23b. DATE
Mar. 4, 1982 | | 23c. NAME OF CEMETERY OR CREMATORY
Cedar Hill Cemetery | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
Baltimore, Maryland | | |
| 24. FUNERAL DIRECTOR
NAME ADDRESS
McGully Funeral Home, 130 E. Fort Ave. Balto. Md. | | | | | | 25a. DATE REC'D. BY REGISTRAR BY REGISTRAR
MAR 2 1982 James J. Nathan | | | |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 2 0 3 5 9 4

REG. NO.

| | | | | | | | | | |
|---|--|--|---|--|-----------------------------------|---|--|--|--|
| 1. DECEASED NAME
(TYPE OR PRINT) | | FIRST MIDDLE LAST | | 2a. DATE OF DEATH | | MONTH DAY YEAR | | 2b. HOUR | |
| Joseph E. Burns | | | | 2-20-82 | | | | 8 A M | |
| 3. SEX | 4. RACE | 5. DATE OF BIRTH | | 6. AGE (IN YEARS LAST BIRTHDAY) | | IF UNDER 1 YEAR | | IF UNDER 24 HRS | |
| Male | White | M 1-18-1896 YEAR | | 86 | | MONTHS DAYS | | HOURS MIN. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) | 7b. CITIZEN OF WHAT COUNTRY? | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH | | | | | |
| Balto. Md. | U.S.A. | | | Baltimore City MD. | | | | | |
| 10. CITY OR TOWN OF DEATH | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | | 12b. KIND OF BUSINESS OR INDUSTRY | | | | |
| Baltimore | Long Green Nursing Home | | Draftsman | | Beth. Steel | | | | |
| 13a. STATE | | 13b. COUNTY | | 13c. CITY OR TOWN | | 13d. INSIDE CITY LIMITS? | | 13e. STREET ADDRESS | |
| Md. | | | | Balto. | | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 2804 Lake Avenue | |
| 14. FATHER'S NAME | | 15. MOTHER'S MAIDEN NAME | | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) | | | | | |
| George V. Burns | | Lula | | 16b. SOCIAL SECURITY NO. 213-07-7696 | | | | | |
| | | | | 17. INFORMANT ADDRESS Arnold, Md. -21012 | | | | | |
| | | | | Mr. Robert Burns - 1259 Dogwood Rd. | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART 1. DEATH WAS CAUSED BY: | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| IMMEDIATE CAUSE (a) acute myocardial infarction | | | | | | | | suddenly | |
| 4100 DUE TO, OR AS A CONSEQUENCE OF (b) coronary atherosclerosis | | | | | | | | 4 yrs | |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO, OR AS A CONSEQUENCE OF (c) with old infarction | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: chronic obstructive bronchitis - 5+ yrs | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? | | | |
| | | | | YES <input type="checkbox"/> NO <input type="checkbox"/> | | YES <input type="checkbox"/> NO <input type="checkbox"/> | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | | | |
| | | | | | | | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK OR NOT WHILE <input type="checkbox"/> AT WORK | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | | | |
| | | | | | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 3/13 1978 to 2/20 1982, that (I) (we) last saw the deceased alive on 1/24 1982 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) did not see the body after death. | | | | | | | | | |
| 22b. SIGNATURE | | | | DEGREE | | 22c. DATE SIGNED | | | |
| William F. Renner | | | | | | | | | |
| 23a. PHYSICIAN'S NAME (TYPE OR PRINT) | | | | 23b. ADDRESS | | | | | |
| William F. Renner | | | | 3222 St Paul St | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) | | 23b. DATE | | 23c. NAME OF CEMETERY OR CREMATORY | | 23d. LOCATION CITY OR TOWN COUNTY STATE | | | |
| Burial | | 2-23-82 | | Parkwood Cem. | | Balto. Md. | | | |
| 24. FUNERAL DIRECTOR NAME | | | | 24b. ADDRESS | | 25a. DATE REC'D. BY REGISTRAR | | 25b. REGISTRAR'S SIGNATURE | |
| John C. Miller Inc-6415 Belair Rd.-21206 | | | | | | FEB 23 1982 | | Frances Jan. Nathan | |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1 - FOR
STATE
REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 2 0 3 5 9 5

REG. NO.

| | | | | | | |
|--|--|--|---|--|---------------------------------------|--|
| 1. DECEASED NAME
(TYPE OR PRINT) WILLIAM J. BUSCHER | | | 2a. DATE OF DEATH
MONTH DAY YEAR
FEBRUARY 14, 1982 | | 2b. HOUR
12:18^{AM} | |
| 3. SEX
Male | | 4. RACE
White | | 5. DATE OF BIRTH
MONTH DAY YEAR
March 31, 1906 | | |
| 7a. BIRTHPLACE
(STATE OR FOREIGN COUNTRY)
Wash. D.C. | | 7b. CITIZEN OF WHAT COUNTRY?
U.S.A. | | 6. AGE (IN YEARS LAST BIRTHDAY)
75 YRS.
IF UNDER 1 YEAR: MONTHS DAYS
IF UNDER 24 HRS: HOURS MIN. | | |
| 10. CITY OR TOWN OF DEATH
Baltimore | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
JOHNS HOPKINS HOSPITAL | | 9. BALTIMORE CITY OR COUNTY OF DEATH
BALTIMORE CITY MD. | | |
| 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
Steamfitter | | 12b. KIND OF BUSINESS OR INDUSTRY | | | | |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)
13a. STATE
Maryland | | | 13b. COUNTY
Frederick | | 13c. CITY OR TOWN
Frederick | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
John Henry Buscher | | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
Antoinette McLaughlin | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
no | | 16b. SOCIAL SECURITY NO.
(IF YES, GIVE WAR OR DATES)
578-05-5346 | | 17. INFORMANT
ADDRESS
Mrs. Gladys B. Buscher, same as above in item #13e | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) EXANGULATION
DUE TO, OR AS A CONSEQUENCE OF (b) RUPTURED AORTA & PERICARDIAL PATCH 1 HR
DUE TO, OR AS A CONSEQUENCE OF (c) THORACIC/MEDIASTINAL SEPSIS
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
1 HR
3 WKS. | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) | | | | | | |
| 19a. DATE OF OPERATION
2/13/82 w/ 2/13/82 | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED
RUPTURED AORTIC PATCH | | 20a. AUTOPSY?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 1-22 , 19 82 , to 2-14 , 19 82 , that (I) (we) last saw the deceased alive on 2-14 , 19 82 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | |
| 22b. SIGNATURE
Richard Scott Stuart MD | | DEGREE
MD | | 22c. DATE SIGNED
2-14-82 | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
RICHARD SCOTT STUART MD | | 22e. ADDRESS
605 N. BROADWAY, BALTIMORE, MD. | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)
Burial | | 23b. DATE
Feb 17, 1982 | | 23c. NAME OF CEMETERY OR CREMATORY
Gate of Heaven | | |
| 23d. LOCATION
CITY OR TOWN COUNTY STATE
Wheaton Montgomery Md. | | 24. FUNERAL DIRECTOR
NAME
Smith Keeney Basford Funeral Home, 106 East Church St., Frederick, Md. 21701 | | 25. LISTED BY REGISTRAR
FEB 19 1982 | | |

BP

March 1, 1910

Dear Mr. J. H. ...

Dear Mr. J. H. ...

Dear Mr. J. H. ...

Dear Mr. J. H. ...

Dear Mr. J. H. ...

Dear Mr. J. H. ...

Dear Mr. J. H. ...

Dear Mr. J. H. ...

Dear Mr. J. H. ...

Dear Mr. J. H. ...

Dear Mr. J. H. ...

Dear Mr. J. H. ...

Dear Mr. J. H. ...

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1071

1- FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

8 2 0 3 5 9 0

| | | | | | | | | | |
|--|--|---|--|---|--|---|--|---|--|
| 1. DECEASED NAME
(TYPE OR PRINT) FIRST MIDDLE LAST SR.
FRANK S. BUSH SR. | | | | 2a. DATE OF DEATH MONTH DAY YEAR
2 23 82 | | | | 2b. HOUR
1:30P M | |
| 3. SEX
MALE | | 4. RACE
WHITE | | 5. DATE OF BIRTH
MONTH DAY YEAR
12 25 17 | | 6. AGE (IN YEARS LAST BIRTHDAY)
64 YRS. | | 7. IF UNDER 1 YEAR MONTHS DAYS
IF UNDER 24 HRS. HOURS MIN. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
VIRGINIA | | 7b. CITIZEN OF WHAT COUNTRY?
U.S.A. | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
BALTIMORE CITY MD. | | | |
| 10. CITY OR TOWN OF DEATH
BALTIMORE | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
VAMC, LOCH RAVEN BLVD. BALTO. MD | | | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
Truck Driver | | 12b. KIND OF BUSINESS OR INDUSTRY
Associated Transport | |
| 13a. STATE
MARYLAND | | 13b. COUNTY | | 13c. CITY OR TOWN
BALTIMORE | | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS
3640 BENSON AVE. 21227 | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
JOSEPH R. BUSH | | | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
MARY A. REYNOLDS | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
YES | | 16b. SOCIAL SECURITY NO.
(IF YES, GIVE WAR OR DATES)
WWII | | 17. INFORMANT
FLORENCE E. BUSH | | ADDRESS
3640 BENSON AVE. 21227 | | | |

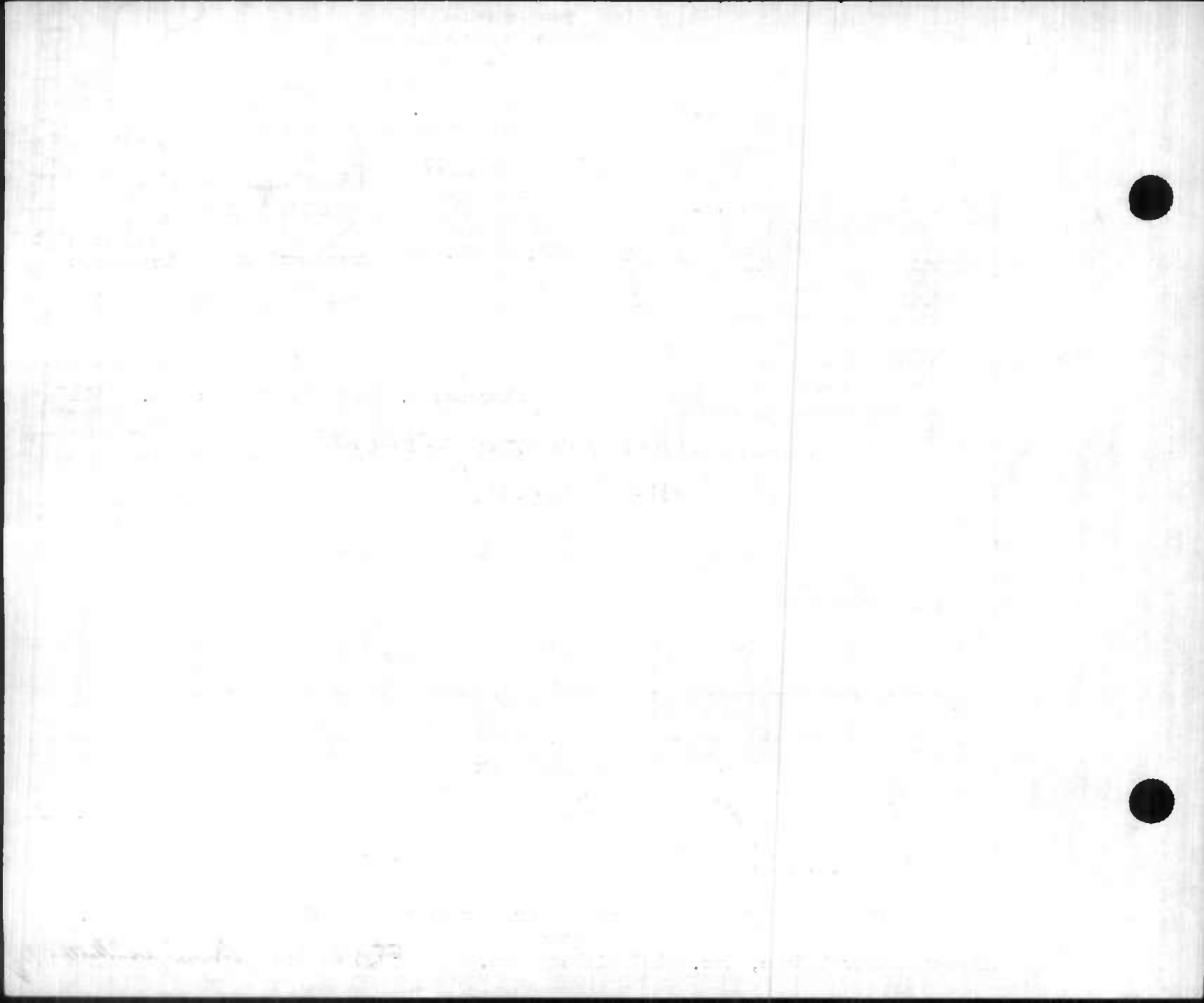
| | | | |
|---|--|--|--|
| 18. CAUSE OF DEATH (Enter only one cause per line or (a), (b), and (c).
PART 1. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>MULTISYSTEM FAILURE</u>
2773
DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost
(b) <u>AMYLOIDOSIS</u>
DUE TO, OR AS A CONSEQUENCE OF
(c) _____ | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
|---|--|--|--|

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a

| | | | | | | | |
|---|--|--|--|--|--|--|--|
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | |
| 22a. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from JANUARY 6, 1982, to FEBRUARY 23, 1982, that <input checked="" type="checkbox"/> (we) last saw the deceased alive on FEBRUARY 23, 1982, and that <input checked="" type="checkbox"/> (our) opinion death occurred on the date and hour and from the causes stated above <input checked="" type="checkbox"/> (we) (did) not view the body after death. | | | | | | | |
| 22b. SIGNATURE
Mark Adams MD | | | | DEGREE
ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> | | 22c. DATE SIGNED
2/23/82 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
MARK ADAMS, MD. | | | | 22e. ADDRESS
3900 LOCH RAVEN BLVD. BALTO. MD. 21218 | | | |

| | | | | | | | |
|--|--|----------------------|--|--|--|---|--|
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)
Burial | | 23b. DATE
2/27/82 | | 23c. NAME OF CEMETERY OR CREMATORY
Loudon Park Cemetery | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
Baltimore Md. | |
| 24. FUNERAL DIRECTOR
NAME ADDRESS
Hubbard Funeral Home, Inc. 4107 Wilkens Ave. 21229 | | | | 25a. DATE REC'D. BY REGISTRAR
FEB 26 1982 | | | |
| | | | | 25b. REGISTRAR'S SIGNATURE
James J. Martin | | | |

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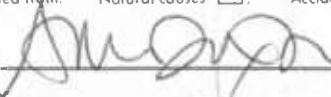

Item 7a g566 4/21/82 gj

STATE OF MARYLAND

DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

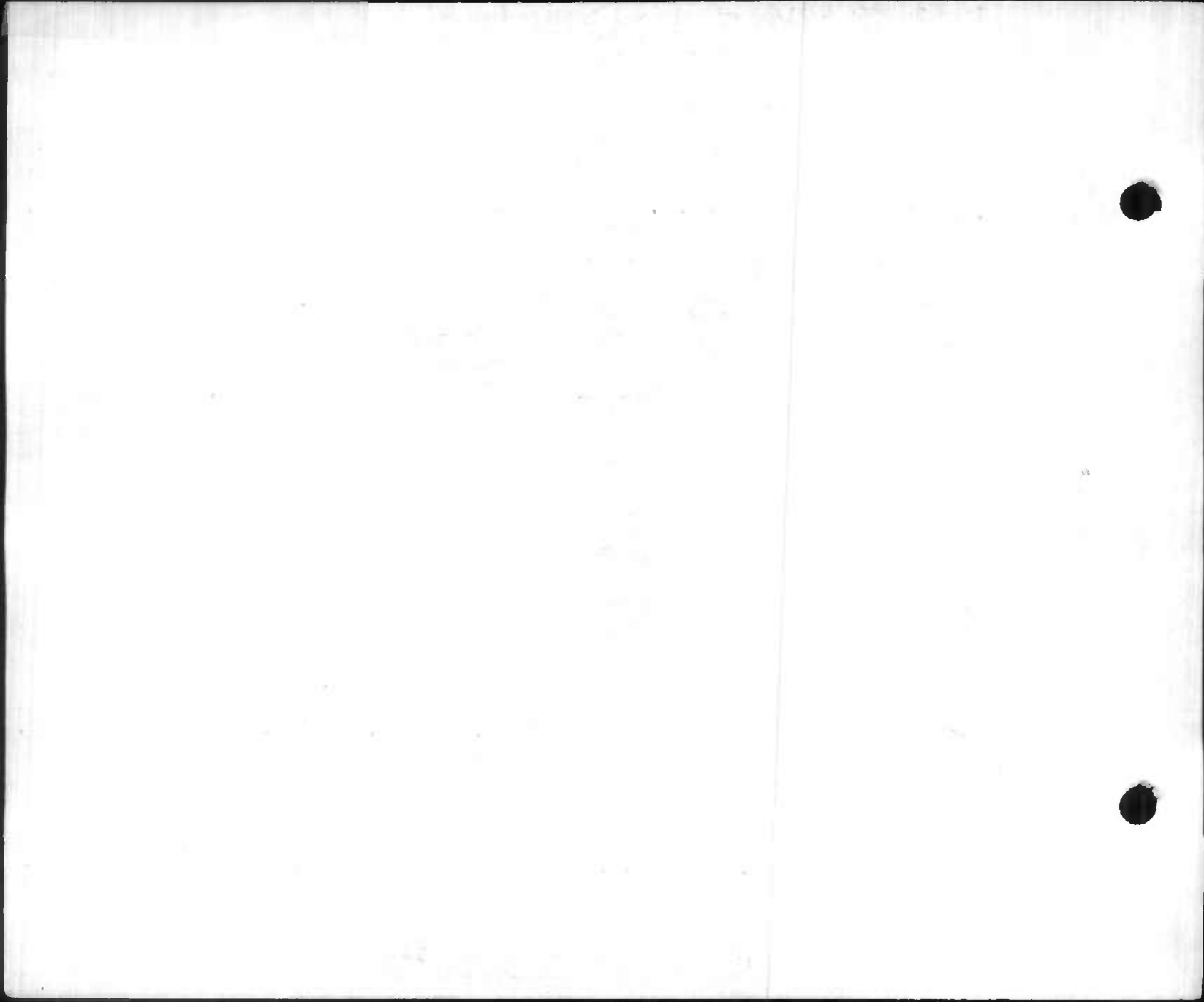
REG. NO.

FOR
1- STATE
REGISTRAR

| | | | | | | | |
|--|------------------|--|---|--|------------------|---|---|
| 1. DECEASED NAME
(TYPE OR PRINT)
FIRST MIDDLE LAST
BERNICE HUGHES BUTLER | | | 2a. DATE KNOWN OF DEATH
ESTIMATED
MONTH DAY YEAR
2 11 1982 | | | 2b. HOUR
M
11:47
P M | |
| 3. SEX
female | 4. RACE
negro | 5. DATE OF BIRTH
MONTH DAY YEAR
MAY 21 1928 | 6. AGE (IN YEARS)
LAST BIRTHDAY YRS.
53 | IF UNDER 1 YR.
MONTHS DAYS
HOURS MIN. | IF UNDER 24 HRS. | 2c. DATE PRONOUNCED DEAD
MONTH DAY YEAR
2 11 1982 | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
N. Carolina | | 7b. CITIZEN OF WHAT COUNTRY?
U.S.A. | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
Baltimore City MD. | |
| 10. CITY OR TOWN OF DEATH
Baltimore | | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
Johns Hopkins Hospital | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)
12b. KIND OF BUSINESS OR INDUSTRY
ROOFING | |
| USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) | | | | | | | |
| 13a. STATE
MARYLAND | | 13b. COUNTY | | 13c. CITY OR TOWN
BALTIMORE | | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 13e. STREET ADDRESS
329 E. 21st Street | | 21218 | | | | | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
LENNIE HUGHES | | | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
CORNELIA DAVIS | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO, OR UNKNOWN)
NO | | 16b. SOCIAL SECURITY NO.
220-20-6336 | | 17. INFORMANT ADDRESS
CALVIN BUTLER/329 E. 21st Street | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I DEATH WAS CAUSED BY:
9654 IMMEDIATE CAUSE (a) <u>Gunshot wound of abdomen (unspecified weapon)</u>
DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a) stating the <u>underlying cause last</u> .
(b) _____
DUE TO, OR AS A CONSEQUENCE OF
(c) _____
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | | | | | | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a). | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | | | | | 20. AUTOPSY?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH | | 21b. TIME OF INJURY
HOUR XX MONTH DAY YEAR
10 P.M. 2-11- 19 82 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)
Subject was shot. | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/>
AT WORK AT WORK | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)
home | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE
329 E. 21st St. Balto. Md. | | | |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input checked="" type="checkbox"/> Undetermined manner <input type="checkbox"/> . | | | | | | | |
| ACTUAL SIGNATURE
 | | TITLE (SPECIFY)
M.D. Assistant MEDICAL EXAMINER | | | | DATE SIGNED
2-12-82 | |
| EXAMINER'S NAME
(TYPE OR PRINT)
Ann M. Dixon, M.D. | | ADDRESS
111 Penn St. | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)
BURIAL | | 23b. DATE
02/15/82 | | 23c. NAME OF CEMETERY OR CREMATORY
BALTIMORE CEMETERY | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
BALTIMORE MARYLAND | |
| 24. FUNERAL DIRECTOR
NAME ADDRESS
MARSHALL W JONES, JR/4101 EDMONDSON AV | | | | 25a. DATE REC'D. BY REGISTRAR
FEB 16 1982 | | 25b. REGISTRAR'S SIGNATURE
 | |

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD., 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY OCCURS, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 OF YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.



TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 1b. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

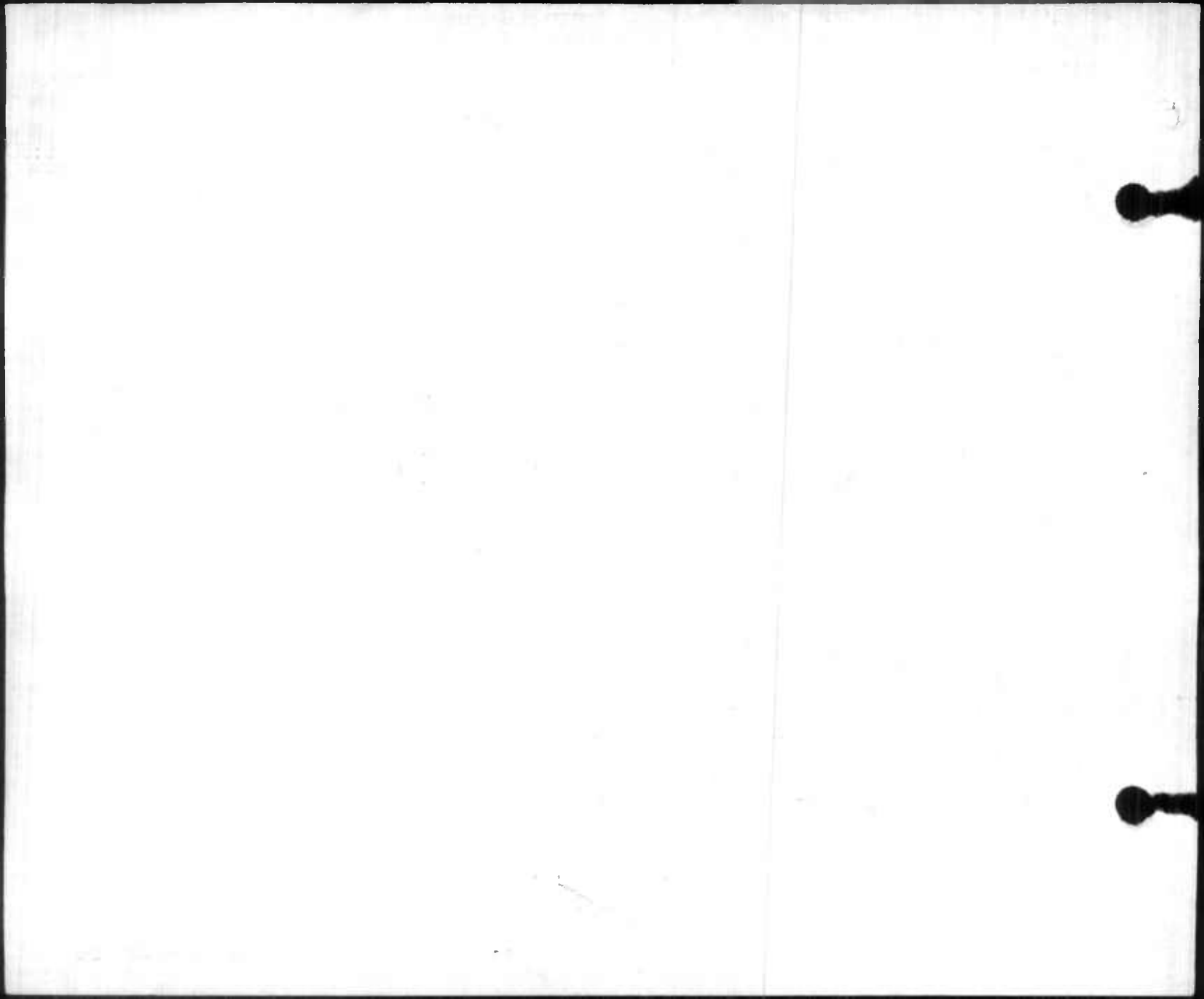
STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | | | | | | | | | | | |
|---|--|------------------|--|---|--|---|--|---|--|---|--|---|--|--|--|--|--|
| 1. DECEASED NAME (TYPE OR PRINT)
FIRST MARGIE MIDDLE ALICE LAST BUTLER | | | | | | | | | | 2a. DATE KNOWN OF DEATH
ESTIMATED <input checked="" type="checkbox"/> MONTH 2 DAY 7 YEAR 19 82 | | | | 2b. HOUR
M 5:30 | | | |
| 3. SEX
female | | 4. RACE
black | | 5. DATE OF BIRTH
MONTH 8 DAY 23 YEAR 09 | | 6. AGE (IN YEARS)
LAST BIRTHDAY 72 YRS. | | IF UNDER 1 YR.
MONTHS DAYS | | IF UNDER 24 HRS.
HOURS MIN | | 2c. DATE PRONOUNCED DEAD
MONTH 2 DAY 7 YEAR 19 82 | | 2d. HOUR
M 5:30 | | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
VA | | | | 7b. CITIZEN OF WHAT COUNTRY?
USA | | | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | | | 9. BALTIMORE CITY OR COUNTY OF DEATH
Baltimore City MD | | | | | |
| 10. CITY OR TOWN OF DEATH
Baltimore | | | | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
1414 N. Gay St. | | | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | | | | 12b. KIND OF BUSINESS OR INDUSTRY | | | |
| USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)
13a. STATE MD 13b. COUNTY Baltimore | | | | | | | | | | 13c. CITY OR TOWN
Baltimore | | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS
1414 N. Gay St. | | | |
| 14. FATHER'S NAME
FIRST Clifton MIDDLE Joyner LAST | | | | | | 15. MOTHER'S MAIDEN NAME
FIRST Rosa MIDDLE E. LAST Sanders | | | | | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO, OR UNKNOWN)
No | | | | 16b. SOCIAL SECURITY NO.
N/A | | | | 17. INFORMANT
Leonard Martin 6570 Pioneer Dr. | | | | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I DEATH WAS CAUSED BY:
4292 IMMEDIATE CAUSE (a) Arteriosclerotic cardiovascular disease
Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last:
(b) DUE TO, OR AS A CONSEQUENCE OF
(c) DUE TO, OR AS A CONSEQUENCE OF
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | | | | | | | | | | | | | | | | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I | | | | | | | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | | | | | | | | 20. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | |
| 21a. EXTERNAL CAUSE WAS
UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH | | | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) | | | | | | | | | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK AT WORK | | | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) | | | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | | | | | | | |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from:
Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> | | | | | | | | | | | | | | | | | |
| ACTUAL SIGNATURE
Thomas D. Smith, M.D. | | | | | | TITLE (SPECIFY)
Deputy Chief MEDICAL EXAMINER | | | | | | DATE SIGNED
2/8/82 | | | | | |
| EXAMINER'S NAME (TYPE OR PRINT)
Thomas D. Smith, M.D. | | | | | | ADDRESS
111 Penn Street, Baltimore, MD 21201 | | | | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)
Burial | | | | 23b. DATE
2/11/82 | | 23c. NAME OF CEMETERY OR CREMATORY
Chapel Grove Cem. | | | | 23d. LOCATION
CITY OR TOWN Windsor COUNTY VA | | | | | | | |
| 24. FUNERAL DIRECTOR
NAME Wm. C. March F/H ADDRESS 1101 E. North Ave. | | | | | | 25a. DATE REC'D. BY REGISTRAR
FEB 10 1982 | | | | | | | | 25b. REGISTRAR'S SIGNATURE | | | |

BP

DHMH - 17
(VR A15 ME (5))
15M 2/80



TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 1b. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR THE FUNERAL DIRECTOR. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITH AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
|--|--|---------------|--|---|--|---|--|----------------------------|--|--|--|---|--|--|--|--|--|--|--|--|--|----------------------------------|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|
| 1. FOR STATE REGISTRAR | | | | | | | | | | 2. DATE KNOWN OF DEATH <input checked="" type="checkbox"/> MONTH DAY YEAR 2 17 19 82 | | | | | | | | | | 2b. HOUR M 11 58 P.M. | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST PAUL V. BUTLER | | | | | | | | | | 2c. DATE PRONOUNCED DEAD MONTH DAY YEAR 2 17 19 82 | | | | | | | | | | 2d. HOUR M 11 58 P.M. | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 3. SEX male | | 4. RACE negro | | 5. DATE OF BIRTH MONTH DAY YEAR 4 12 1914 | | 6. AGE (IN YEARS LAST BIRTHDAY) 67 YRS. | | IF UNDER 1 YR. MONTHS DAYS | | IF UNDER 24 HRS. HOURS MIN | | 7. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Md | | | | | | | | | | 7b. CITIZEN OF WHAT COUNTRY? USA | | | | | | | | | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | | | | | | | | | 9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City MD | | | | | | | | | |
| 10. CITY OR TOWN OF DEATH Baltimore | | | | | | | | | | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 2039 Pennsylvania Ave. | | | | | | | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | | | | | | | | | | 12b. KIND OF BUSINESS OR INDUSTRY | | | | | | | | | | | | | | | | | | | | | |
| 13a. STATE Md | | | | | | | | | | 13b. COUNTY | | | | | | | | | | 13c. CITY OR TOWN Baltimore | | | | | | | | | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | | | | | | | | 13e. STREET ADDRESS 2039 Pennsylvania Ave | | | | | | | | | | | |
| 14. FATHER'S NAME FIRST MIDDLE LAST George C. Butler | | | | | | | | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Georganna Johnson | | | | | | | | | | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) No | | | | | | | | | | 16b. SOCIAL SECURITY NO. 218-10-4876 | | | | | | | | | | 17. INFORMANT ADDRESS Elizabeth Butler 2039 Pennsylvania | | | | | | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) 4292 Arteriosclerotic cardiovascular disease
Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last
(b)
(c) | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | | | | | | | | | PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | | | | | | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | | | | | | | | | | 20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH | | | | | | | | | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | | | | | | | | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK | | | | | | | | | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) | | | | | | | | | | 21f. LOCATION CITY OR TOWN COUNTY STATE | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> | | | | | | | | | | TITLE (SPECIFY) M.D. Assistant MEDICAL EXAMINER | | | | | | | | | | DATE SIGNED 2-18-82 | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| ACTUAL SIGNATURE [Signature] | | | | | | | | | | EXAMINER'S NAME (TYPE OR PRINT) Ann M. Dixon, M.D. | | | | | | | | | | ADDRESS 111 Penn St. | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | | | | | | | | | | 23b. DATE 2/23/82 | | | | | | | | | | 23c. NAME OF CEMETERY OR CREMATORY King Memorial Park | | | | | | | | | | 23d. LOCATION CITY OR TOWN COUNTY STATE Balto Co Md | | | | | | | | | | | | | | | | | | | | | |
| 24. FUNERAL DIRECTOR NAME William C. March F/P | | | | | | | | | | ADDRESS 1101 E. North Ave | | | | | | | | | | 25a. DATE REC'D. BY REGISTRAR FEB 19 1982 | | | | | | | | | | 25b. REGISTRAR'S SIGNATURE [Signature] | | | | | | | | | | | | | | | | | | | | | |

(34)

12-1-19

12-1-19

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 2 0 3 6 0 0

FOR
 1- STATE
 REGISTRAR

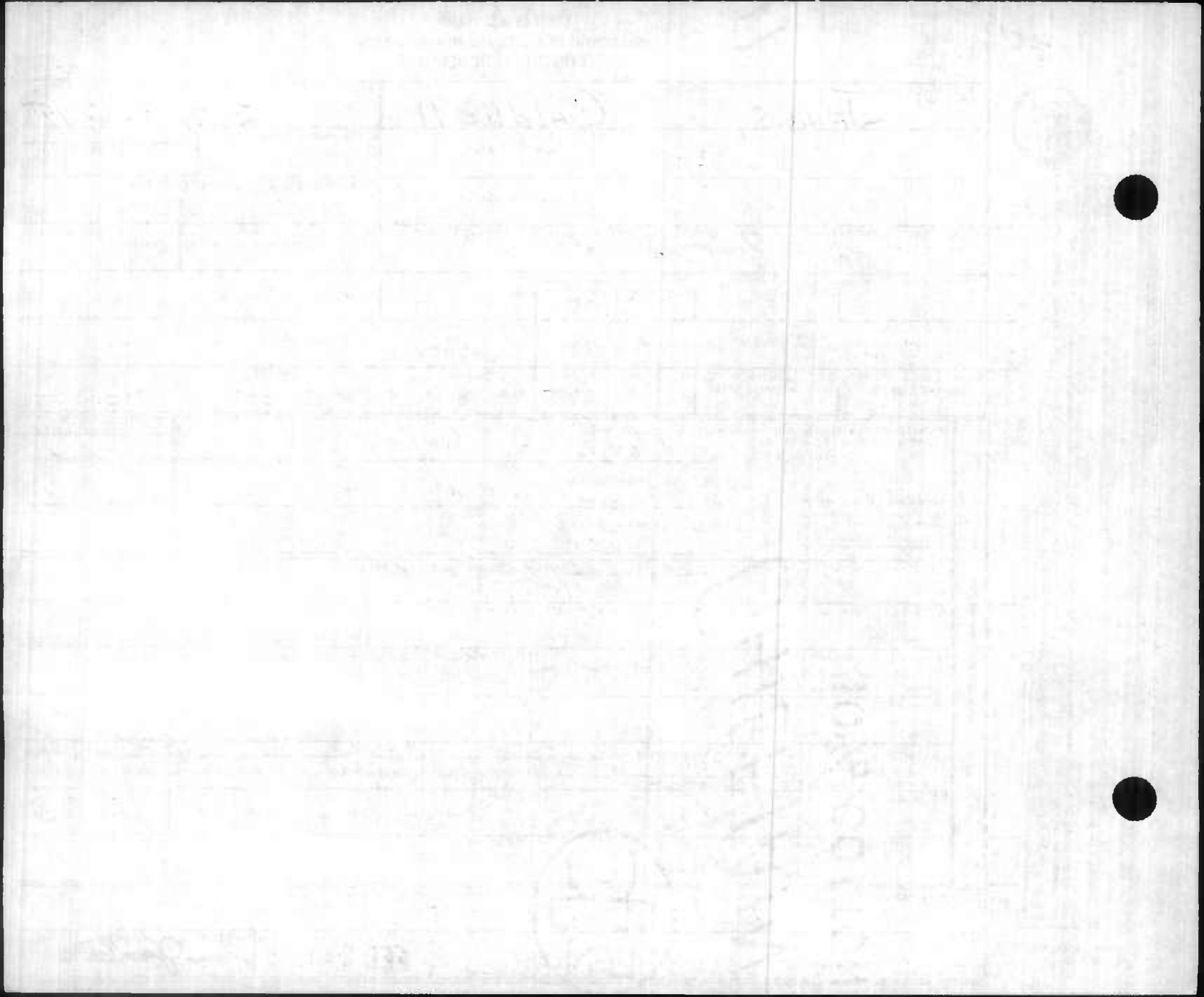
REG. NO.

| | | | | | |
|---|---|--|---|---|--|
| 1 DECEASED NAME
(TYPE OR PRINT) James Caldwell | | | 2a. DATE OF DEATH
MONTH DAY YEAR
2 21 82 | | 2b. HOUR
2:49 PM |
| 3 SEX
Male | 4 RACE
Black | 5. DATE OF BIRTH
MONTH DAY YEAR
1 23 19 | | 6 AGE (IN YEARS LAST BIRTHDAY)
63
YRS. MONTHS DAYS HOURS MIN. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
S.C. | 7b. CITIZEN OF WHAT COUNTRY?
USA | 8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9 BALTIMORE CITY OR COUNTY OF DEATH
Baltimore City MD | |
| 10 CITY OR TOWN OF DEATH
Baltimore | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
City Hospital | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE) | | 12b. KIND OF BUSINESS OR INDUSTRY |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)
13a. STATE MD 13b. COUNTY 13c. CITY OR TOWN Baltimore | | | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | 13e. STREET ADDRESS
907 N. Belnord Avenue | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
George Caldwell | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
Mary Hill | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN) Yes | | 16b. SOCIAL SECURITY NO.
241-14-6937 | | 17 INFORMANT ADDRESS
Viola M. Caldwell 907 N. Belnord Ave. | |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY.
IMMEDIATE CAUSE (a) Cardiac Arrest
4100
DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last
(b) myocardial infarction
DUE TO, OR AS A CONSEQUENCE OF
(c) coronary artery disease
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
1 year | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | |
| 22a. I certify that (I) (this hospital) attended the deceased from 8/21/82 19 82 , to 2/21/82 19 82 , that (I) (we) lost saw the deceased alive on 2/21/82 19 82 , and that in my (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | |
| 22b. SIGNATURE
Dean Kross | | DEGREE
MD | | 22c. DATE SIGNED
2/21/82 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
Dean Kross | | 22e. ADDRESS
Balt City Hosp, Eastern Ave | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)
Burial | | 23b. DATE
2/26/82 | 23c. NAME OF CEMETERY OR CREMATORY
Md. Veteran Cem. | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
Crownsville Baltimore MD |
| 24 FUNERAL DIRECTOR
NAME
Wm. C. March f/h | | ADDRESS
1101 E. North Ave. | | 25a. DATE REC'D. BY REGISTRAR FEB 22 1982 25b. REGISTRAR'S SIGNATURE
Thomas J. [Signature] | |

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, this certificate should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

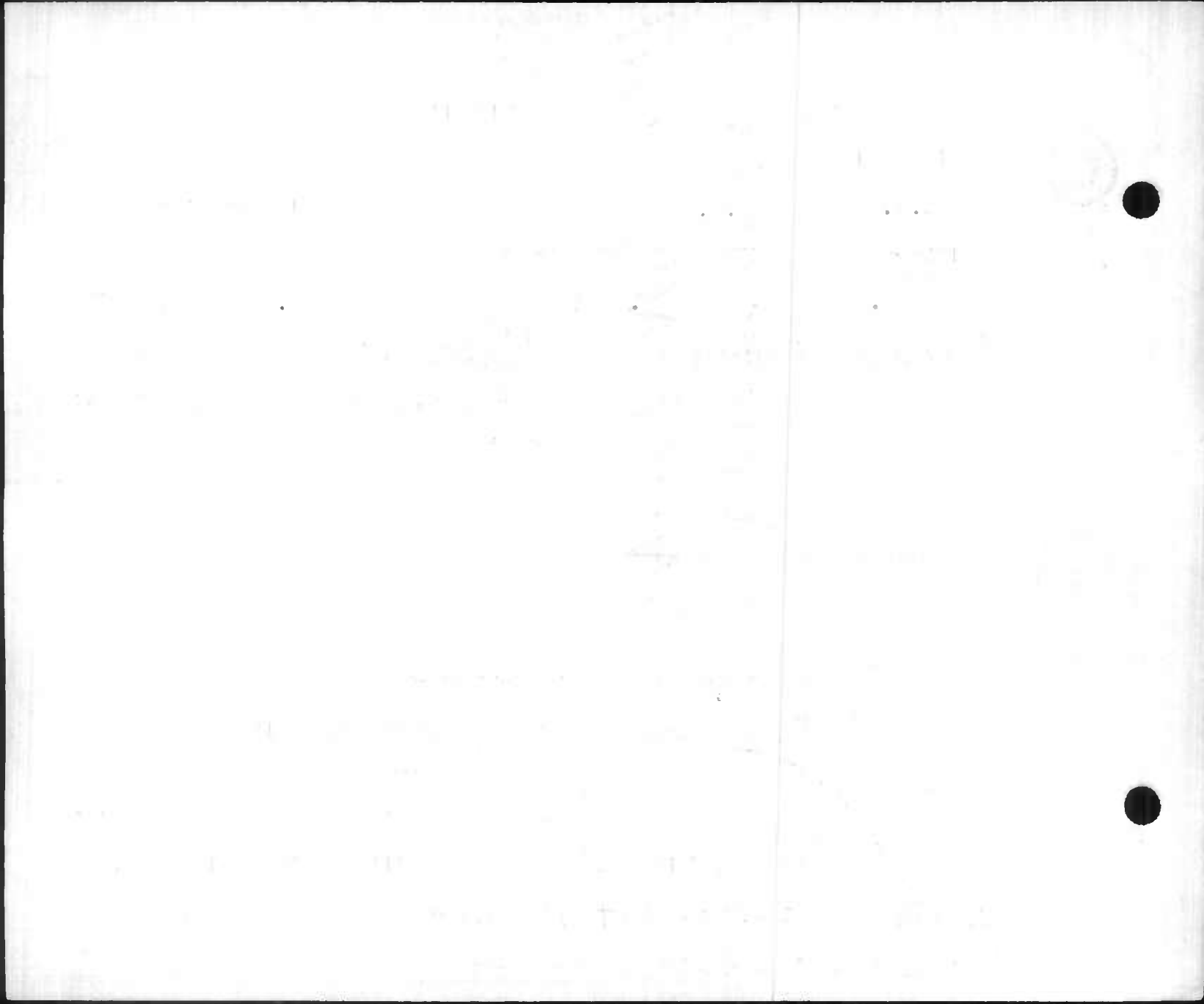


TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSPORT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
|--|--|---------|--|--|--|-------------------|--|--|--|--|--|--------------------------------------|--|---|--|--|--|--|--|---|--|--|--|--|--|--|--|--|--|
| 1- FOR STATE REGISTRAR | | | | | | | | | | 2 0 3 6 0 1 | | | | | | | | | | | | | | | | | | | |
| 1. DECEASED NAME (TYPE OR PRINT) | | | | | | | | | | 2a. DATE KNOWN OF DEATH | | | | | | | | | | 2b. HOUR | | | | | | | | | |
| Joseph Caldwell | | | | | | | | | | xx MONTH DAY YEAR 2 2 19 82 | | | | | | | | | | M | | | | | | | | | |
| 3. SEX | | 4. RACE | | 5. DATE OF BIRTH | | 6. AGE (IN YEARS) | | IF UNDER 1 YR. | | IF UNDER 24 HRS. | | 7c. DATE PRONOUNCED DEAD | | 7d. HOUR | | | | | | | | | | | | | | | |
| Male | | Black | | 9 20 20 | | 61 YRS. | | MONTHS DAYS | | HOURS MIN. | | 2 2 19 82 | | 3:44A M | | | | | | | | | | | | | | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) | | | | 7b. CITIZEN OF WHAT COUNTRY? | | | | 8. MARRIED | | | | 9. BALTIMORE CITY OR COUNTY OF DEATH | | | | | | | | | | | | | | | | | |
| S.C. | | | | U.S. | | | | WIDOWED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | | | Baltimore City, MD. | | | | | | | | | | | | | | | | | |
| 10. CITY OR TOWN OF DEATH | | | | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | | | | 12b. KIND OF BUSINESS OR INDUSTRY | | | | | | | | | | | | | | | | | |
| Baltimore | | | | 1202 W. Fayette Street | | | | | | | | | | | | | | | | | | | | | | | | | |
| USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) | | | | | | | | | | 13d. INSIDE CITY LIMITS? | | | | | | | | | | 13e. STREET ADDRESS | | | | | | | | | |
| 13a. STATE | | | | | | | | | | 13b. COUNTY | | 13c. CITY OR TOWN | | YES <input type="checkbox"/> NO <input type="checkbox"/> 1202 W. Fayette St | | | | | | | | | | | | | | | |
| 14. FATHER'S NAME | | | | | | | | | | 15. MOTHER'S MAIDEN NAME | | | | | | | | | | | | | | | | | | | |
| David McFaden | | | | | | | | | | Rachael Lewis | | | | | | | | | | | | | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? | | | | | | | | | | 16b. SOCIAL SECURITY NO. | | | | | | | | | | 17. INFORMANT | | | | | | | | | |
| (YES, NO, OR UNKNOWN) | | | | | | | | | | (IF YES, GIVE WAR OR DATES) | | | | | | | | | | Georgia Johnson 110 Willard St. Sister | | | | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | | | | | | | | | | | | | | | | | | |
| PART I DEATH WAS CAUSED BY: | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 9660 IMMEDIATE CAUSE (a) Stab wound to chest | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause lost. | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| (b) | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| (c) | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | | | | | | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | | | | | | | | | | 20. AUTOPSY? | | | | | | | | | |
| | | | | | | | | | | | | | | | | | | | | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | | | | | | | |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH | | | | | | | | | | 21b. TIME OF INJURY | | | | | | | | | | 21c. HOW INJURY OCCURRED | | | | | | | | | |
| | | | | | | | | | | 3:40xx 2 2 19 82 | | | | | | | | | | Subject stabbed | | | | | | | | | |
| 21d. INJURY OCCURRED | | | | | | | | | | 21e. PLACE OF INJURY | | | | | | | | | | 21f. LOCATION | | | | | | | | | |
| WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK AT WORK | | | | | | | | | | home | | | | | | | | | | 1202 W. Fayette St. Balto. MD. | | | | | | | | | |
| 22a. I certify that I took charge of the remains described above, held an | | | | | | | | | | Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion | | | | | | | | | | | | | | | | | | | |
| death resulted from | | | | | | | | | | Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input checked="" type="checkbox"/> Undetermined manner <input type="checkbox"/> | | | | | | | | | | | | | | | | | | | |
| ACTUAL SIGNATURE | | | | | | | | | | TITLE (SPECIFY) | | | | | | | | | | DATE SIGNED | | | | | | | | | |
| Thomas D. Smith, M.D. | | | | | | | | | | Deputy Chief | | | | | | | | | | 2/2/82 | | | | | | | | | |
| EXAMINER'S NAME (TYPE OR PRINT) | | | | | | | | | | ADDRESS | | | | | | | | | | 111 Penn St. Balto., MD. | | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) | | | | | | | | | | 23b. DATE | | | | | | | | | | 23c. NAME OF CEMETERY OR CREMATORY | | | | | | | | | |
| Burial | | | | | | | | | | 2-6-82 | | | | | | | | | | Mt Auburn | | | | | | | | | |
| 24. FUNERAL DIRECTOR | | | | | | | | | | 25a. DATE REC'D. BY REGISTRAR | | | | | | | | | | 25b. REGISTRAR'S SIGNATURE | | | | | | | | | |
| Cowanwright | | | | | | | | | | 2700 Edmondson ave. | | | | | | | | | | FEB 5 1982 | | | | | | | | | |

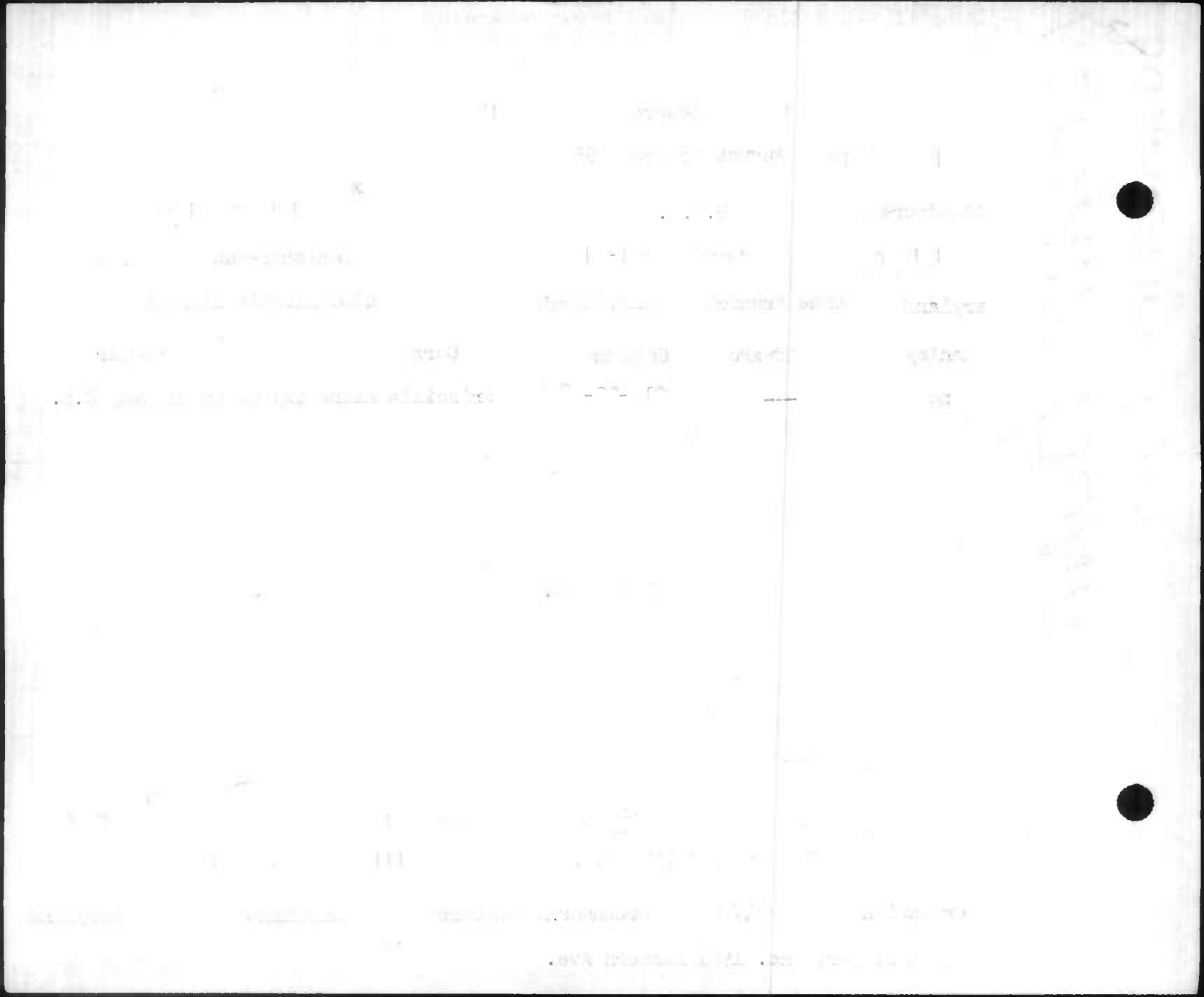


TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 IN YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 24 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

Items #18a-22a Film G566 4/6/82 RESTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | | | | | | | | |
|--|---------|----------------------------------|--|--|------------------|---|--|---|--|---|--|--|--|--|
| 1. DECEASED NAME
(TYPE OR PRINT) | | | 2a. DATE KNOWN OF DEATH | | | 2b. DATE OF DEATH | | | 2c. DATE PRONOUNCED DEAD | | | 2d. HOUR | | |
| FIRST MIDDLE LAST
Donald Edward Calhoun | | | MONTH DAY YEAR
2 22 1982 | | | MONTH DAY YEAR
2 22 1982 | | | MONTH DAY YEAR
2 22 1982 | | | M
3:40 P | | |
| 3. SEX | 4. RACE | 5. DATE OF BIRTH | 6. AGE (IN YEARS) | IF UNDER 1 YR. | IF UNDER 24 HRS. | 7. BIRTHPLACE (STATE OR FOREIGN COUNTRY) | | | 7b. CITIZEN OF WHAT COUNTRY? | | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | |
| Male | White | MONTH DAY YEAR
August 25 1926 | LAST BIRTHDAY
55 YRS. | MONTHS | DAYS | Baltimore | | | U.S.A. | | | | | |
| 10. CITY OR TOWN OF DEATH | | | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | | | 12b. KIND OF BUSINESS OR INDUSTRY | | | | | |
| Baltimore | | | Church Hospital | | | Longshoreman | | | ILA | | | | | |
| 13a. STATE | | | 13b. COUNTY | | | 13c. CITY OR TOWN | | | 13d. INSIDE CITY LIMITS? | | | 13e. STREET ADDRESS | | |
| Maryland | | | Anne Arundel | | | Glen Burnie | | | YES <input type="checkbox"/> NO <input type="checkbox"/> | | | 4500 Ritchie Highway | | |
| 14. FATHER'S NAME | | | 15. MOTHER'S MAIDEN NAME | | | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? | | | 16b. SOCIAL SECURITY NO. | | | 17. INFORMANT | | |
| FIRST MIDDLE LAST
Manley Edward Calhoun | | | FIRST MIDDLE LAST
Cora Wampler | | | no | | | 215-22-6831 | | | Priscilla Kline 423 Crain Highway S.E. | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) | | | | | | | | | | | | | | |
| PART I DEATH WAS CAUSED BY: | | | | | | | | | | | | | | |
| IMMEDIATE CAUSE (a) Subdural hematoma with complications | | | | | | | | | | | | | | |
| 9889 | | | | | | | | | | | | | | |
| Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. | | | | | | | | | | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF | | | | | | | | | | | | | | |
| (b) | | | | | | | | | | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF | | | | | | | | | | | | | | |
| (c) | | | | | | | | | | | | | | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 | | | | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | | | | | | 20. AUTOPSY? | | | | |
| | | | | | | | | | | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | | |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH | | | | 21b. TIME OF INJURY | | | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2) | | | | | | |
| | | | | HOUR A.M. MONTH DAY YEAR
? 2/11/1982 | | | | Unknown | | | | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK | | | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, ETC.) | | | | 21f. LOCATION | | | | | | |
| | | | | Unknown | | | | Unknown | | | | | | |
| 22a. I certify that the above description of the remains described above held an | | | | | | | | | | | | | | |
| death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input checked="" type="checkbox"/> | | | | | | | | | | | | | | |
| 22b. I certify that the above description of the remains described above held an | | | | Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion | | | | | | | | | | |
| ACTUAL SIGNATURE | | | | TITLE (SPECIFY) | | | | | | DATE SIGNED | | | | |
| Thomas D. Smith, M.D. | | | | M.D. Deputy Chief | | | | | | 2/23/82 | | | | |
| EXAMINER'S NAME (TYPE OR PRINT) | | | | ADDRESS | | | | | | 111 Penn St. Balto., Md. | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) | | | | 23b. DATE | | 23c. NAME OF CEMETERY OR CREMATORY | | | | 23d. LOCATION | | | | |
| Cremation | | | | 2/24/82 | | Greenmount Cemetery | | | | Baltimore Maryland | | | | |
| 24. FUNERAL DIRECTOR | | | | 25a. DATE REC'D. BY REGISTRAR | | | | | | 25b. REGISTRAR'S SIGNATURE | | | | |
| NAME ADDRESS
Lilly & Zeiler, Inc. 1901 Eastern Ave. | | | | FEB 25 1982 | | | | | | Name Jan [Signature] | | | | |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. The permit may be carbon copied. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to the cremation or burial. **IMPORTANT:** If item 21 is marked or item 18 shows any injury, the medical examiner must be notified or an autopsy requested.1- FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | |
|---|---|--|---|--|
| 1. DECEASED NAME
(TYPE OR PRINT) LENA FIRST CAPLAN MIDDLE LAST | | | 2a. DATE OF DEATH
MONTH 2 DAY 11 YEAR 82 2b. HOUR 11:15 P.M. | |
| 3 SEX
FEMALE | 4 RACE
WHITE | 5. DATE OF BIRTH
MONTH 7 DAY 20 YEAR 1884 | | 6 AGE (IN YEARS LAST BIRTHDAY)
98 97 YRS |
| 7a BIRTHPLACE (STATE OR FOREIGN COUNTRY)
GERMANY | 7b CITIZEN OF WHAT COUNTRY?
USA | 8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9 BALTIMORE CITY OR COUNTY OF DEATH
BALTO. CITY MD |
| 10 CITY OR TOWN OF DEATH
BALTIMORE | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
LEVINDALE HEBREW GERIATRIC CENTER | | 12a USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
HOUSEWIFE | 12b KIND OF BUSINESS OR INDUSTRY
AT HOME |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)
13a STATE MARYLAND 13b COUNTY BALTIMORE 13c CITY OR TOWN BALTIMORE 13d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e STREET ADDRESS APT. 302
2500 W. BELVEDERE AVE. 21215 | | |
| 14. FATHER'S NAME
FIRST LEVI MIDDLE OPPENHEIMER LAST LEVOR | | 15 MOTHER'S MAIDEN NAME
FIRST RACHEL MIDDLE LEVOR LAST LEVOR | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN) NO | | 16b. DATE OF DEATH
213-20-9972
216-46-7412 | | |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) 4100 Acute myocardial infarction
DUE TO, OR AS A CONSEQUENCE OF (b) Arteriosclerotic cardiovascular disease yrs.
DUE TO, OR AS A CONSEQUENCE OF (c) 2 days | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
2 days |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) |
| 21d. INJURY OCCURRED
WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE |
| 22a. I certify that (I) (this hospital) attended the deceased from 2/10/82 to 2/11/82 , that (I) (we) last saw the deceased alive on 2/10/82 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) did not view the body after death. | | | | |
| 22b. SIGNATURE
Steven A. Levinson MD DEGREE MD | | | | 22c. DATE SIGNED
2/12/82 |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
STEVEN A. LEVINSON, M.D. | | 22e. ADDRESS
LEVINDALE - BALTO., MD | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)
BURIAL | 23b. DATE
FEB. 14, 1982 | 23c. NAME OF CEMETERY OR CREMATORY
HEBREW FRIENDSHIP | 23d. LOCATION
CITY OR TOWN BALTIMORE COUNTY MARYLAND | |
| 24. FUNERAL DIRECTOR SOL LEVINSON & BROS., INC.
NAME 6010 REISTERSTOWN RD. BALTO., MD 21215 | | 25a. DATE REC'D. BY REGISTRAR FEB 17 1982 REGISTRAR'S SIGNATURE [Signature] | | |

TEAMOFFT
CWA 53-NA-50
CWA 53-NA-50

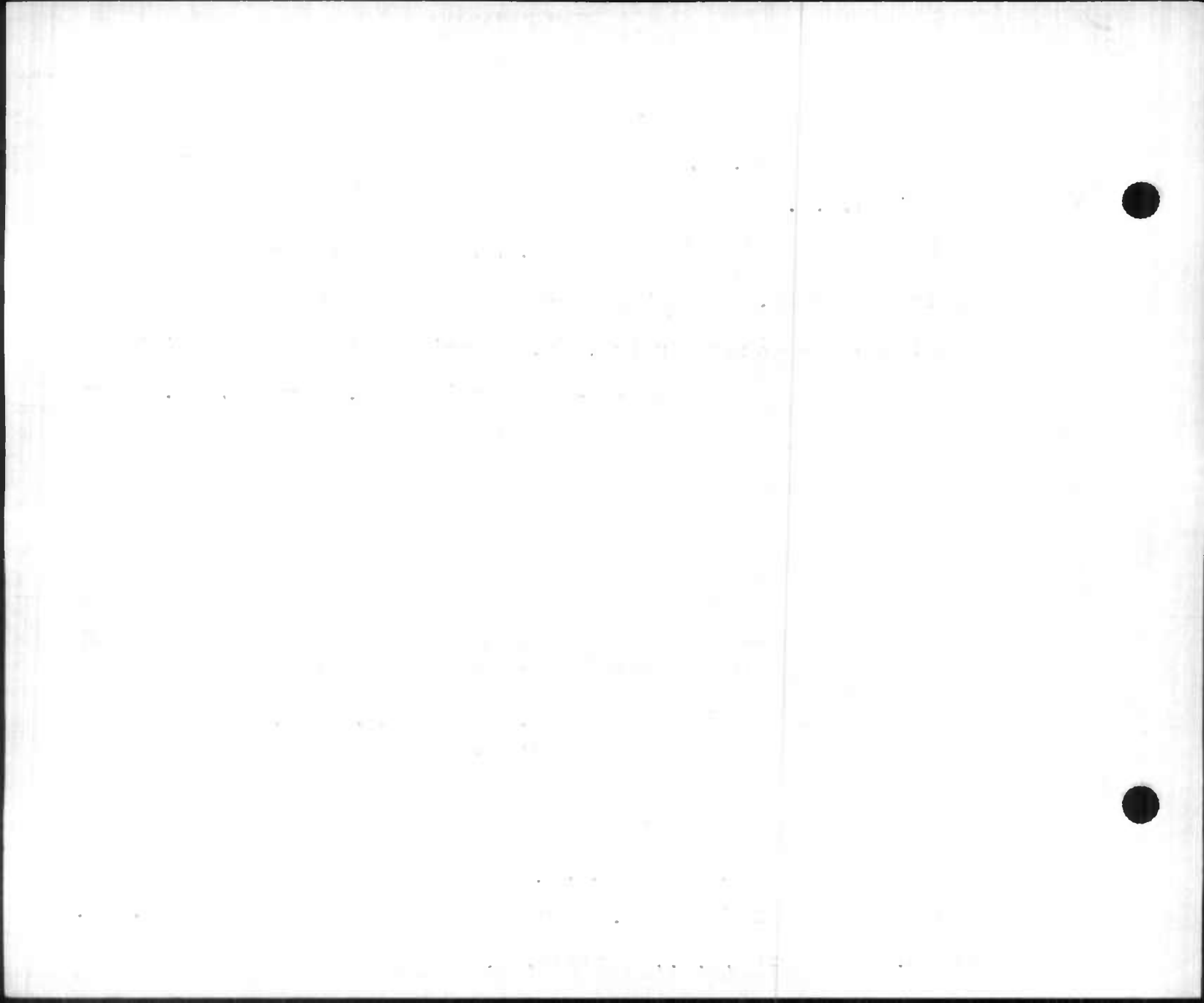
TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 IN YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED IN THE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

MEDICAL CERTIFICATION

| STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH | | | | | | | | | | REG. NO. 2 0 3 6 0 4 | |
|--|--|-----------------------|--|---|--|---|--|--|---------------------|--|--|
| 1. FOR STATE REGISTRAR | | | | | | | | | | | |
| 1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST
FRANCIS S. CARRICO | | | | | | 2b. DATE KNOWN OF DEATH ESTI- MATED <input checked="" type="checkbox"/> MONTH DAY YEAR
2-10-82 | | 2d. HOUR
M 4:4 P | | | |
| 3. SEX
male | | 4. RACE
white | | 5. DATE OF BIRTH MONTH DAY YEAR
Oct. 9, 1961 | | 6. AGE (IN YEARS LAST BIRTHDAY) 20 YRS. | | 7c. DATE PRONOUNCED DEAD
2-10-82 | | 24 HOUR | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
Washington, D.C. | | | | 7b. CITIZEN OF WHAT COUNTRY?
USA | | | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
Baltimore City MD. | |
| 10. CITY OR TOWN OF DEATH
Baltimore | | | | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
University Hospital S.T.U. | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)
Meat Cutter | | 12b. KIND OF BUSINESS OR INDUSTRY | |
| USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) | | | | | | | | | | | |
| 13a. STATE
Maryland | | 13b. COUNTY
Montg. | | 13c. CITY OR TOWN
Clarksburg | | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 13e. STREET ADDRESS
26400 Haines Road | | | |
| 14. FATHER'S NAME FIRST MIDDLE LAST
Hamilton Spencer Carrico, Jr. | | | | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST
Maria Gloria Zammichieli | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)
No | | | | 16b. SOCIAL SECURITY NO.
219-90-8265 | | 17. INFORMANT ADDRESS
Hamilton S. Carrico, Jr. Item 13 | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I DEATH WAS CAUSED BY: Multiple injuries
8150 IMMEDIATE CAUSE (a) _____
Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. }
DUE TO, OR AS A CONSEQUENCE OF (b) _____
DUE TO, OR AS A CONSEQUENCE OF (c) _____ | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1. | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | | | | | | 20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH | | | | 21b. TIME OF INJURY
3:31 AM MONTH DAY YEAR
2-5-82 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)
driver of auto/fixed object impact | | | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK | | | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)
highway | | 21f. LOCATION
St Rt. 355 4/10mi. N. of Ste. Frederick, Maryland
Rt. 80 | | | | | |
| 22a. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> . | | | | | | | | | | | |
| ACTUAL SIGNATURE <i>Margarita A. Koroll</i> | | | | | | TITLE (SPECIFY)
M.D. Assistant MEDICAL EXAMINER | | | DATE SIGNED 2-11-82 | | |
| EXAMINER'S NAME (TYPE OR PRINT) Margarita A. Koroll, M.D. | | | | | | ADDRESS 11 Penn Street | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)
Burial | | | | 23b. DATE
2/13/82 | | 23c. NAME OF CEMETERY OR CREMATORY
Mt. Olivet | | | | 23d. LOCATION CITY OR TOWN COUNTY STATE
Frederick Fred. Md. | |
| 24. FUNERAL DIRECTOR NAME ADDRESS
Olin L. Molesworth, P.A., Damascus, Md. | | | | | | 25a. DATE REC'D. BY REGISTRAR
FEB 17 1982 | | 25b. REGISTRAR'S SIGNATURE | | | |

BP

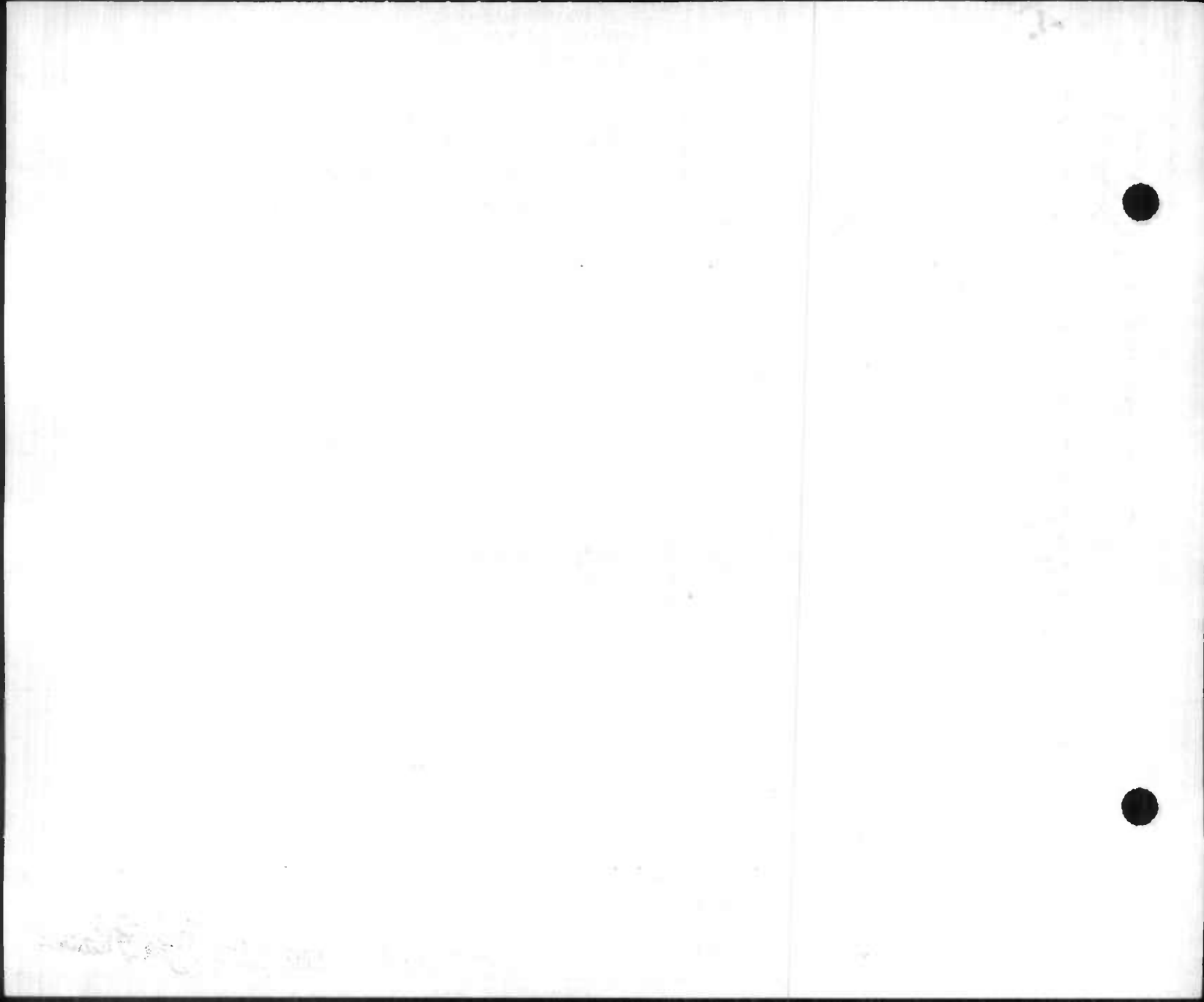
DHMH - 17
(VR A15 ME (5))
15M 2/80



TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS ANTICIPATED, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE REGISTRAR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 24 HOURS AFTER DEATH. WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

MEDICAL CERTIFICATION

| STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH | | | | | | | | | | REG. NO. 6 2 0 3 6 0 5 | | | | | | | | | |
|--|--|------------------|--|---|--|---|--|--|--|---|--|--|--|-------------------------------------|--|--|--|--|--|
| 1- FOR STATE REGISTRAR | | | | | | 2a. DATE KNOWN OF DEATH | | | | | | 2b. HOUR | | | | | | | |
| 1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST
S JOHN W. CARRINGTON | | | | | | 2c. DATE PRONOUNCED DEAD MONTH DAY YEAR
2 7 1982 | | | | | | 2d. HOUR MIN.
5:36 a M | | | | | | | |
| 3. SEX
male | | 4. RACE
negro | | 5. DATE OF BIRTH MONTH DAY YEAR
8 28 21 | | 6. AGE (IN YEARS) LAST BIRTHDAY YRS.
60 | | IF UNDER 1 YR. MONTHS DAYS | | IF UNDER 24 HRS. HOURS MIN. | | 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
VA | | 7b. CITIZEN OF WHAT COUNTRY?
USA | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
Baltimore City MD. | |
| 10. CITY OR TOWN OF DEATH
Baltimore | | | | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
1121 N. Monroe St. | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | | | | 12b. KIND OF BUSINESS OR INDUSTRY | | | | | | | |
| 13a. STATE
MD | | | | 13b. COUNTY | | 13c. CITY OR TOWN
Baltimore | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS
3026 Baker St. | | | | | | | | | |
| 14. FATHER'S NAME FIRST MIDDLE LAST
Walter J. Carrington | | | | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST
Maggie Cohiness | | | | | | | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)
No | | | | 16b. SOCIAL SECURITY NO.
217-12-6221 | | 17. INFORMANT ADDRESS
Jean Spence 2302 Jefferson St. | | | | | | | | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I DEATH WAS CAUSED BY:
4029 IMMEDIATE CAUSE (a) Hypertensive cardiovascular disease
Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.
(b) _____
(c) _____
DUE TO, OR AS A CONSEQUENCE OF
DUE TO, OR AS A CONSEQUENCE OF | | | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | | | | | | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a): | | | | | | | | | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | | | | | | | | 20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | | | |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH | | | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR
P.M. 19 | | | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) | | | | | | | | | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/> | | | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) | | | | 21f. LOCATION CITY OR TOWN COUNTY STATE | | | | | | | | | | | |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> . | | | | | | | | | | | | | | | | | | | |
| ACTUAL SIGNATURE <i>Ann M. Dixon</i> | | | | | | TITLE (SPECIFY)
M.D. Assistant MEDICAL EXAMINER | | | | DATE SIGNED 2-7-82 | | | | | | | | | |
| EXAMINER'S NAME (TYPE OR PRINT)
Ann M. Dixon, M.D. | | | | | | ADDRESS
111 Penn St. | | | | | | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)
Burial | | | | 23b. DATE
2/13/82 | | 23c. NAME OF CEMETERY OR CREMATORY
Church Cem. | | | | 23d. LOCATION CITY OR TOWN COUNTY
Daniel Town VA | | | | | | | | | |
| 24. FUNERAL DIRECTOR NAME
Wm. C. March F/H | | | | | | ADDRESS
1101 E. North Ave. | | | | 25a. DATE REC'D. BY REGISTRAR
FEB 9 1982 | | 25b. REGISTRAR'S SIGNATURE
<i>Frances Jan Nathan</i> | | | | | | | |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

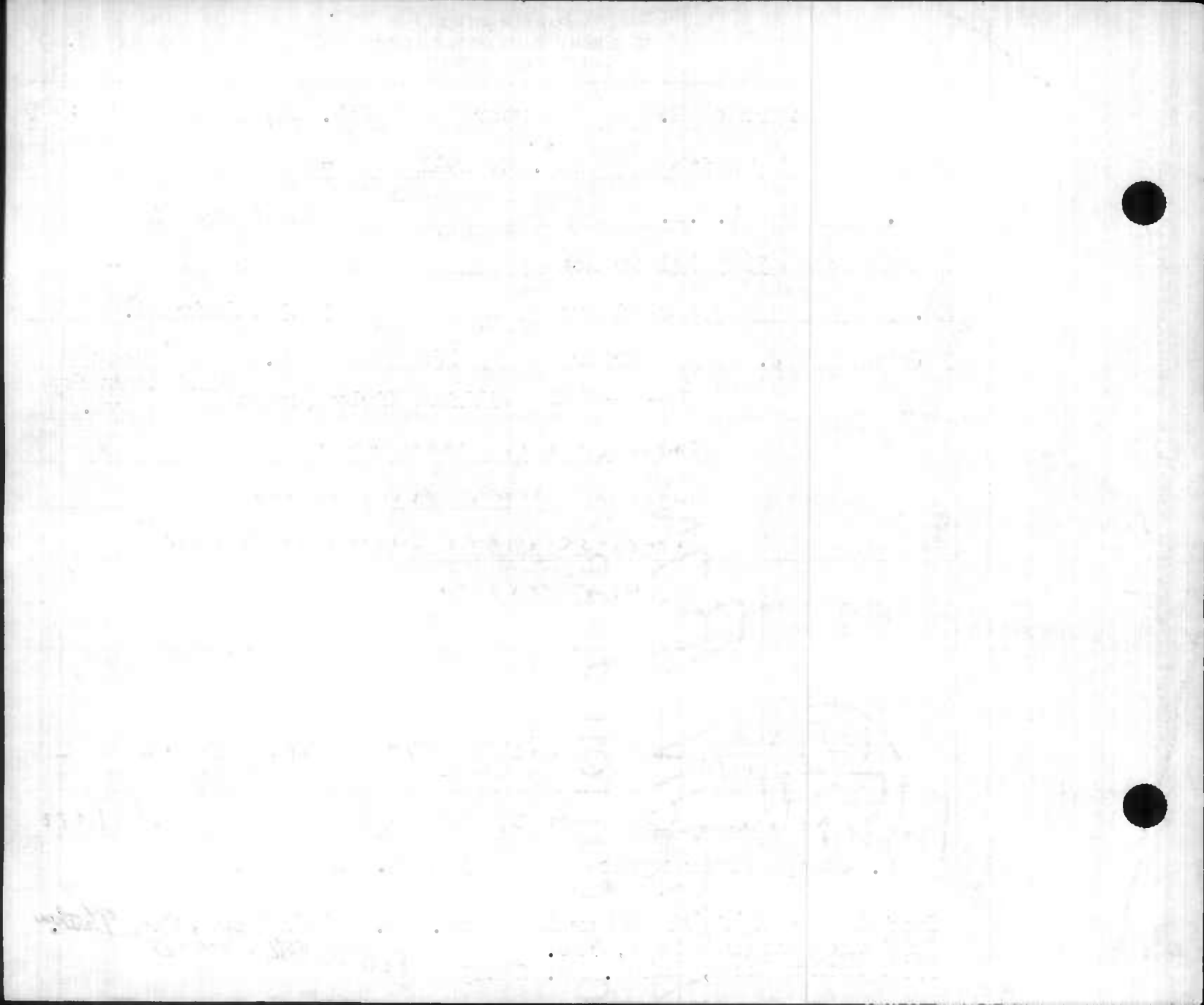
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 2 0 3 6 0 6

REG. NO.

| | | | | | |
|---|---|--|---|---|--|
| 1. DECEASED NAME
(TYPE OR PRINT)
FIRST MIDDLE LAST
Gertrude E. Carter | | | 2a. DATE OF DEATH
MONTH DAY YEAR
Feb. 21, 1982 | | 2b. HOUR
6:30p |
| 3. SEX
Female | 4. RACE
White | 5. DATE OF BIRTH
MONTH DAY YEAR
Aug. 29 1911 | | 6. AGE (IN YEARS LAST BIRTHDAY)
70 YRS. | IF UNDER 1 YEAR
MONTHS DAYS
IF UNDER 74 HRS.
HOURS MIN. |
| 7. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
Md. | 7b. CITIZEN OF WHAT COUNTRY?
U.S.A. | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
Baltimore City MD. | |
| 10. CITY OR TOWN OF DEATH
Baltimore | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
3613 Belair Road | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)
Homemaker | | 12b. KIND OF BUSINESS OR INDUSTRY
- |
| 13a. STATE
Md. | 13b. COUNTY | 13c. CITY OR TOWN
Baltimore | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | 13e. STREET ADDRESS
3613 Belair Rd. | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
John J. Carter | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
Ida E. Heck | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)
no | 16b. SOCIAL SECURITY NO.
212-32-2882 | 17. INFORMANT
ADDRESS
William Kirby (cousin) 3110 Kentucky Ave. | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART 1. DEATH WAS CAUSED BY:
4110
IMMEDIATE CAUSE (a) FATAL CARDIAC ARRHYTHMIA
DUE TO, OR AS A CONSEQUENCE OF
(b) CORONARY ARTERY INSUFFICIENCY
DUE TO, OR AS A CONSEQUENCE OF
(c) ATHEROSCLEROTIC CARDIOVASC. DISEASE
CONDITIONS, if any, which gave rise to immediate cause (a), stating the underlying cause lost. | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)
HYPERTENSION | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input type="checkbox"/> | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) | |
| 21d. INJURY OCCURRED
WHITE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | |
| 22a. I certify that (I) (this hospital) attended the deceased from JUNE , 19 77 , to 2/21 , 19 82 , that (I) (we) last saw the deceased alive on 12/11 , 19 81 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (each) did not view the body after death. | | | | | |
| 22b. SIGNATURE
Joseph D. Notarangelo | | DEGREE
M.D. | | 22c. DATE SIGNED
2/22/1982 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
Dr. Joseph Notarangelo | | 22e. ADDRESS
301 St. Paul Place | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)
Burial | 23b. DATE
2/24/82 | 23c. NAME OF CEMETERY OR CREMATORY
Moreland Mem. Pk. | | 23d. LOCATION
CITY OR TOWN COUNTY
Baltimore, MD. | |
| 24. FUNERAL DIRECTOR
Schimunek Funeral Home, Inc. | | 25a. DATE REC'D. BY REGISTRAR
FEB 23 1982 | | 25b. SIGNATURE
James S. Notarangelo | |
| 25c. ADDRESS
3331 Brehms Lane, Balto. Md. 21213 | | | | | |

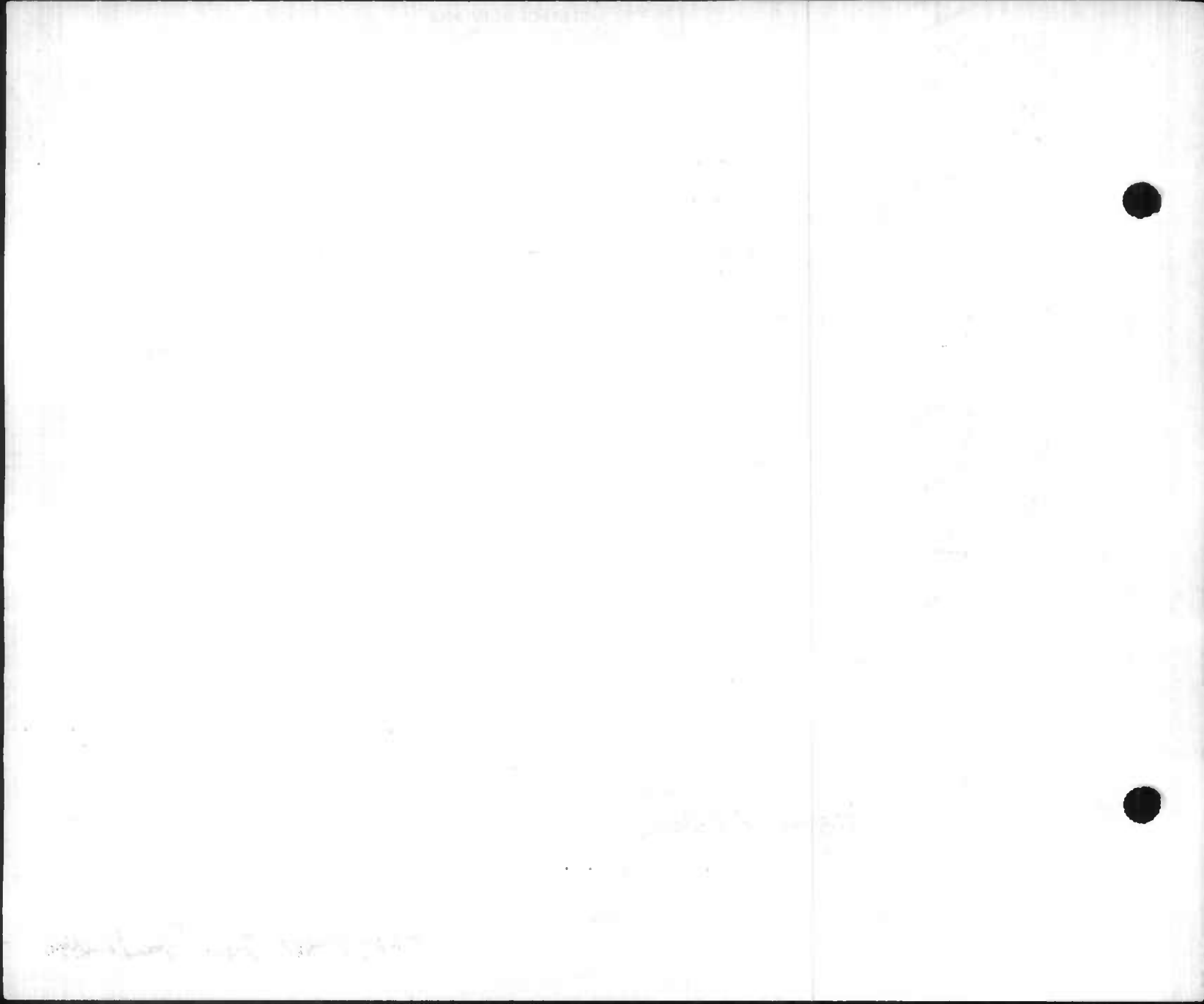


TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

MEDICAL CERTIFICATION

| STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH | | | | | | | | | | REG. NO. 7203607 | | | | | |
|---|---------|---|--|---|--------|--|--|--|--|----------------------------|-----|---------|----------|-------|----------|
| 1. FOR STATE REGISTRAR | | 1. DECEASED NAME (TYPE OR PRINT) | | FIRST | MIDDLE | LAST | | 2a. DATE KNOWN OF DEATH | | MONTH | DAY | YEAR | 2b. HOUR | | |
| | | Michael W Carter | | | | | | X | | 2 | 19 | 1982 | M | | |
| 3. SEX | 4. RACE | 5. DATE OF BIRTH | | 6. AGE (IN YEARS) | | IF UNDER 1 YR. | | IF UNDER 24 HRS. | | 2c. DATE PRONOUNCED DEAD | | MONTH | DAY | YEAR | 2d. HOUR |
| Male | White | June 23, 57 | | 24 YRS. | | | | | | 2 | | 19 | 1982 | P. 43 | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) | | 7b. CITIZEN OF WHAT COUNTRY? | | 8. MARRIED | | NEVER MARRIED | | 9. BALTIMORE CITY OR COUNTY OF DEATH | | | | | | | |
| Maryland | | U.S.A. | | WIDOWED | | DIVORCED | | Baltimore City, | | MD | | | | | |
| 10. CITY OR TOWN OF DEATH | | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | | 12b. KIND OF BUSINESS OR INDUSTRY | | | | | | | | | |
| Baltimore | | University Hospital - STU | | Plumbers Helper | | | | | | | | | | | |
| 13a. STATE | | 13b. COUNTY | | 13c. CITY OR TOWN | | 13d. INSIDE CITY LIMITS? | | 13e. STREET ADDRESS | | | | | | | |
| Maryland | | | | Baltimore | | YES X NO | | 4103 E. Northern Pkwy | | | | | | | |
| 14. FATHER'S NAME | | 15. MOTHER'S MAIDEN NAME | | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? | | 16b. SOCIAL SECURITY NO. | | 17. INFORMANT | | ADDRESS | | | | | |
| Clyde | | Carter Sr | | Claire | | Morris | | Mr Clyde Carter Sr | | Same | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) | | PART I DEATH WAS CAUSED BY: | | IMMEDIATE CAUSE (a) | | Multiple Visceral & Skeletal Injuries | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | | | | | | |
| 8147 | | | | (b) | | | | | | | | | | | |
| | | | | (c) | | | | | | | | | | | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a). | | | | | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | | 20. AUTOPSY? | | YES X NO | | | | | | | | | |
| | | | | | | | | | | | | | | | |
| 21a. EXTERNAL CAUSE WAS UNDERLYING X OR CONTRIBUTING CAUSE OF DEATH | | 21b. TIME OF INJURY | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) | | subject was struck by auto | | | | | | | | | |
| | | 9:30 A.M. 2 19 1982 | | | | | | | | | | | | | |
| 21d. INJURY OCCURRED WHILE AT WORK NOT WHILE AT WORK X | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) | | 21f. LOCATION | | Pulaski Hgwy. & Middle River Road, Balto. Co., Md. | | | | | | | | | |
| | | road | | | | | | | | | | | | | |
| 22a. I certify that I took charge of the remains described above, held on death resulted from: | | Natural causes | | Accident X | | Suicide | | Homicide | | Undetermined manner | | | | | |
| | | | | | | | | | | | | | | | |
| ACTUAL SIGNATURE | | Virginia L. Dolan | | TITLE (SPECIFY) | | Assistant | | MEDICAL EXAMINER | | DATE SIGNED | | 2-20-82 | | | |
| | | | | | | | | | | | | | | | |
| EXAMINER'S NAME (TYPE OR PRINT) | | Virginia L. Dolan, M.D. | | ADDRESS | | 111 Penn Street | | | | | | | | | |
| | | | | | | | | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) | | 23b. DATE | | 23c. NAME OF CEMETERY OR CREMATORY | | 23d. LOCATION CITY OR TOWN | | COUNTY | | STATE | | | | | |
| Burial | | 2/23/82 | | Parkwood | | Baltimore, Maryland | | | | | | | | | |
| 24. FUNERAL DIRECTOR NAME | | Leonard J Ruck Inc. | | ADDRESS | | Baltimore, Maryland | | 25a. DATE REC'D BY REGISTRAR | | 25b. REGISTRAR'S SIGNATURE | | | | | |
| | | | | | | | | FEB 22 1982 | | James J. Nathan | | | | | |

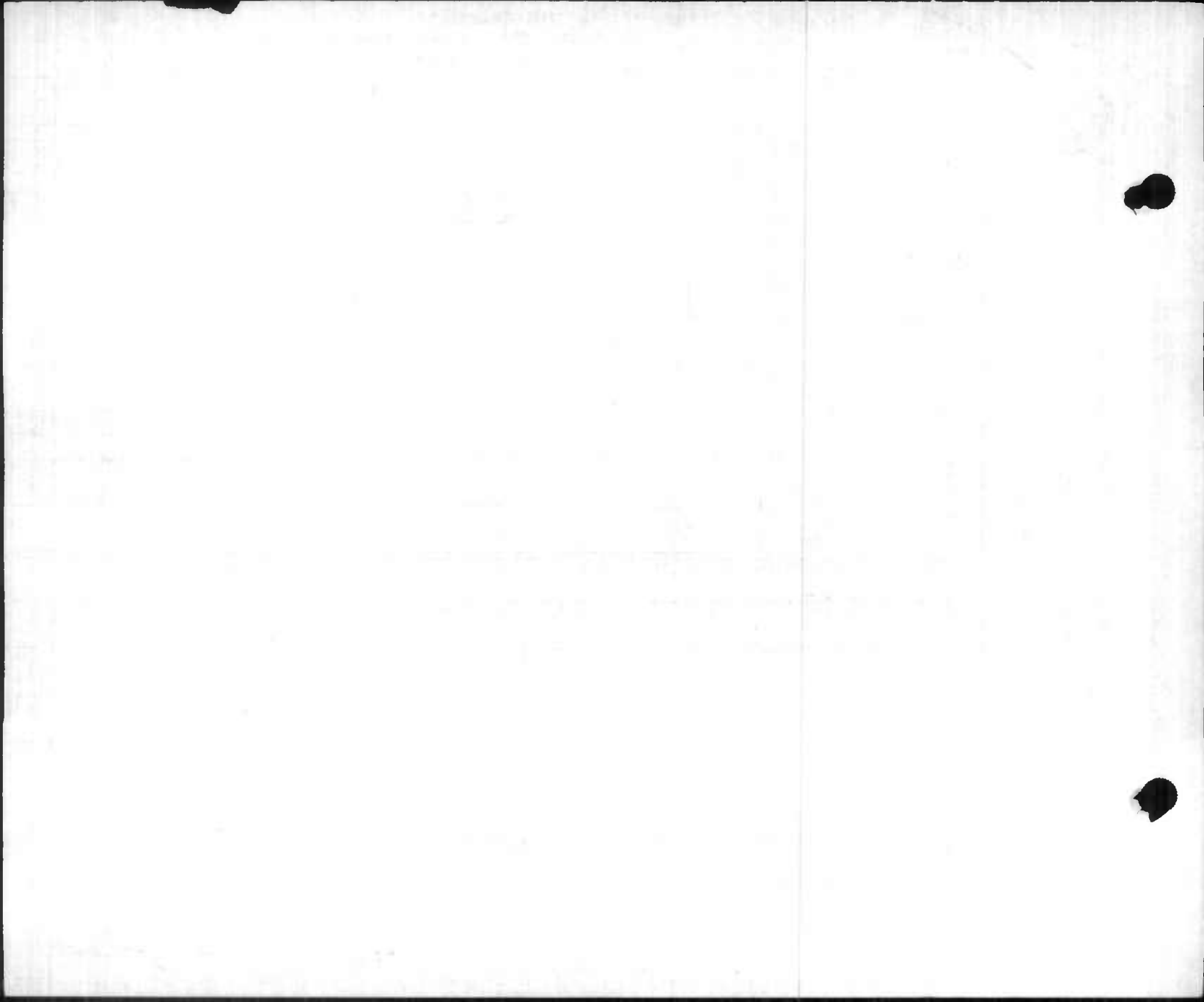
BP



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of time death. Report retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH | | | | | | | | | |
|--|--|---|--|---|--|---|--|--|--|
| 1. FOR
STATE
REGISTRAR | | REG. NO. | | | | | | | |
| 1. DECEASED NAME
(TYPE OR PRINT)
FIRST MIDDLE LAST
Virginia CARTER | | | | 2a. DATE OF DEATH MONTH DAY YEAR 2b. HOUR
02 19 82 10:10 PM | | | | | |
| 3. SEX
FEMALE | | 4. RACE
black | | 5. DATE OF BIRTH
MONTH DAY YEAR
05 30 99 | | 6. AGE (IN YEARS LAST BIRTHDAY)
83 | | 7. IF UNDER 1 YEAR
MONTHS DAYS
IF UNDER 24 HRS
HOURS MIN | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
Virginia | | 7b. CITIZEN OF WHAT COUNTRY?
USA | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
BALTIMORE CITY MD. | | | |
| 10. CITY OR TOWN OF DEATH
BALTIMORE | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
SINAI Hospital | | | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE) | | 12b. KIND OF BUSINESS OR INDUSTRY | |
| 13a. STATE
MD | | 13b. COUNTY | | 13c. CITY OR TOWN
Balto | | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS
3008 Dupont Avenue | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
Will Watts | | | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
Susan | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
No | | 16b. SOCIAL SECURITY NO.
(IF YES, GIVE WAR OR DATES)
220126083 | | 17. INFORMANT ADDRESS
Betty Taylor 3008 Dupont Avenue | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>CANCER of uterus</u>
1790
DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b) _____
DUE TO, OR AS A CONSEQUENCE OF
(c) _____
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
1 year | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)
CVA, DEHYDRATION | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | | | |
| 21d. INJURY OCCURRED
WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>2/1</u> 19 <u>82</u> to <u>2/19</u> 19 <u>82</u> , that (I) (we) last saw the deceased alive on <u>2/19</u> 19 <u>82</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death. | | | | | | | | | |
| 22b. SIGNATURE
W. Zitzmann | | | | DEGREE
ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> | | 22c. DATE SIGNED
2/19/82 | | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
WILLIAM ZITZMAN | | | | 22e. ADDRESS
SINAI Hospital | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)
Burial | | 23b. DATE
2/22/82 | | 23c. NAME OF CEMETERY OR CREMATORY
Cedar Hill Cemetery | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
Baltimore, Maryland | | | |
| 24. FUNERAL DIRECTOR
NAME ADDRESS
Wm. C. March F/H Inc./1101 E. North Avenue | | | | 25a. DATE RECEIVED BY REGISTRAR
FEB 22 1982 | | 25b. REGISTRAR'S SIGNATURE | | | |

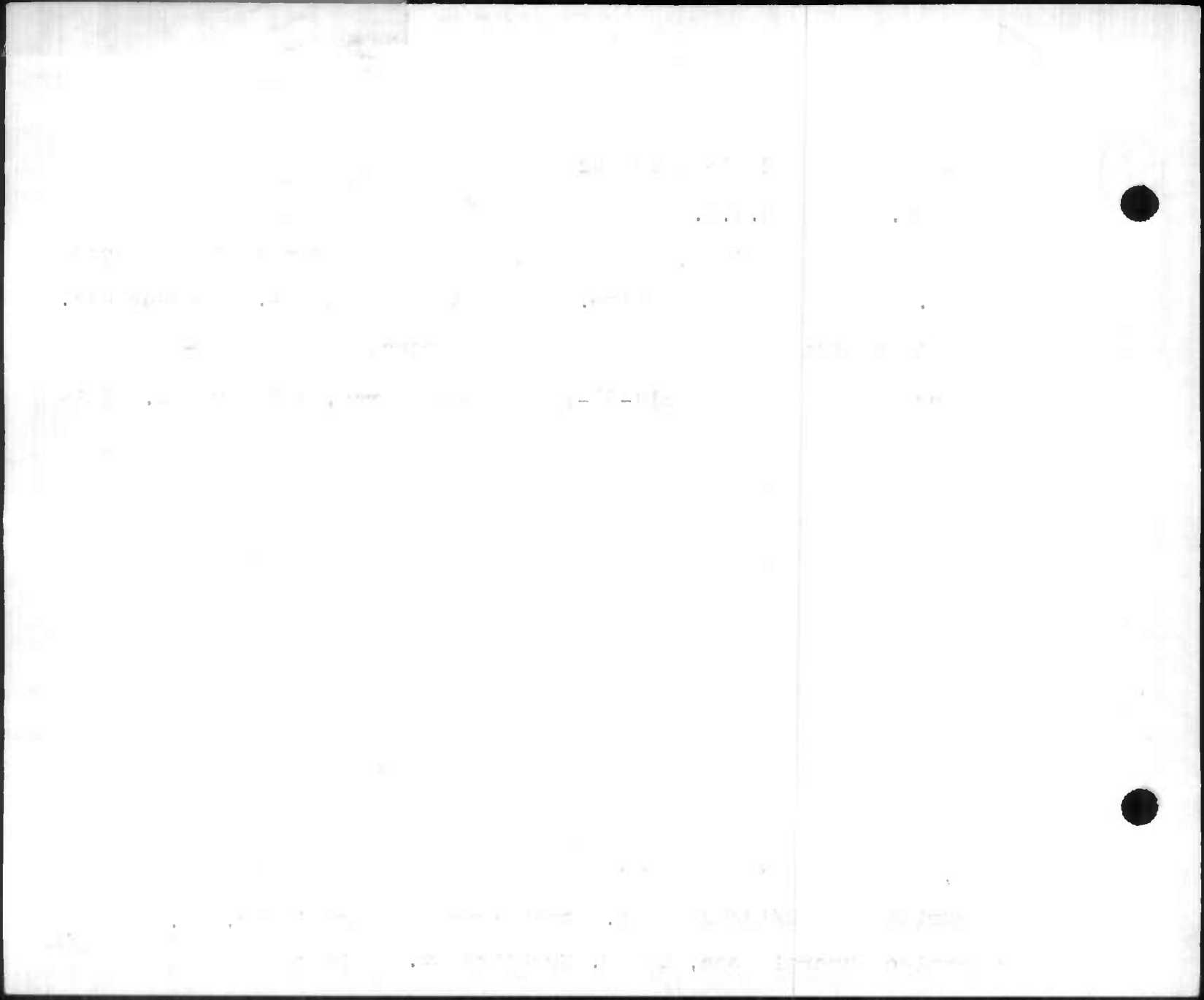


TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM-3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | | | | | | | | | | | | | | | | | |
|--|--|---------------|--|--|--|--|--|--|--|---|--|---|--|--|--|--|--|--|--|---------------------|--|---------------------|--|
| 1- STATE REGISTRAR | | | | | | | | | | 2- DATE KNOWN OF DEATH <input checked="" type="checkbox"/> MONTH DAY YEAR 2 6 19 82 | | | | | | | | | | 2b. HOUR M 6:48 P M | | | |
| 1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST ANNA E CARUSO | | | | | | | | | | 7c. DATE PRONOUNCED DEAD MONTH DAY YEAR 2 6 19 82 | | | | | | | | | | 2d. HOUR M 6:48 P M | | | |
| 3. SEX female | | 4. RACE white | | 5. DATE OF BIRTH MONTH DAY YEAR 2 15 1899 | | 6. AGE (IN YEARS LAST BIRTHDAY) 82 YRS. | | IF UNDER 1 YR. MONTHS DAYS | | IF UNDER 24 HRS. HOURS MIN | | 7d. DATE PRONOUNCED DEAD MONTH DAY YEAR 2 6 19 82 | | | | | | | | | | 2d. HOUR M 6:48 P M | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Md. | | | | 7b. CITIZEN OF WHAT COUNTRY? U.S.A. | | | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | | | 9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City MD. | | | | | | | | | | | |
| 10. CITY OR TOWN OF DEATH Baltimore | | | | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 3921 Mt. Pleasant Ave. | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) homemaker | | | | 12b. KIND OF BUSINESS OR INDUSTRY home | | | | | | | | | | | |
| 13a. STATE Md. | | 13b. COUNTY | | 13c. CITY OR TOWN Balto. | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS 3921 Mt. Pleasant Ave. | | | | | | | | | | | | | | | |
| 14. FATHER'S NAME FIRST MIDDLE LAST Thomas Blum | | | | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Frances - | | | | | | | | | | | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) no | | | | 16b. SOCIAL SECURITY NO. 214-74-7763 | | | | 17. INFORMANT ADDRESS Joseph Trau, 2807 3rd St. 21219 | | | | | | | | | | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART 1 DEATH WAS CAUSED BY:
4029 IMMEDIATE CAUSE (a) Hypertensive & arteriosclerotic cardiovascular disease
Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last:
(b) _____
(c) _____
DUE TO, OR AS A CONSEQUENCE OF
DUE TO, OR AS A CONSEQUENCE OF
DUE TO, OR AS A CONSEQUENCE OF | | | | | | | | | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | | | | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a): | | | | | | | | | | | | | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | | | | | | | | | | 20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | | | | | |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH | | | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) | | | | | | | | | | | | | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/> | | | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) | | | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | | | | | | | | | | | | | |
| 22a. I certify that I took charge of the remains described above, held on death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion | | | | | | | | | | | | | | | | | | | | | | | |
| ACTUAL SIGNATURE | | | | TITLE (SPECIFY) M.D. Assistant MEDICAL EXAMINER | | | | | | | | | | DATE SIGNED 2-7-82 | | | | | | | | | |
| EXAMINER'S NAME (TYPE OR PRINT) Ann M. Dixon, M.D. | | | | ADDRESS 111 Penn St. | | | | | | | | | | | | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | | | | 23b. DATE 2/10/82 | | 23c. NAME OF CEMETERY OR CREMATORY St. Stanislaus | | | | 23d. LOCATION CITY OR TOWN COUNTY STATE Baltimore, Md. | | | | | | | | | | | | | |
| 24. FUNERAL DIRECTOR NAME Zannino Funeral Home, 263 S. Conkling | | | | 25a. DATE REC'D. BY REGISTRAR FEB 10 1982 | | | | 25b. REGISTRAR'S SIGNATURE Francesco Santhron | | | | | | | | | | | | | | | |



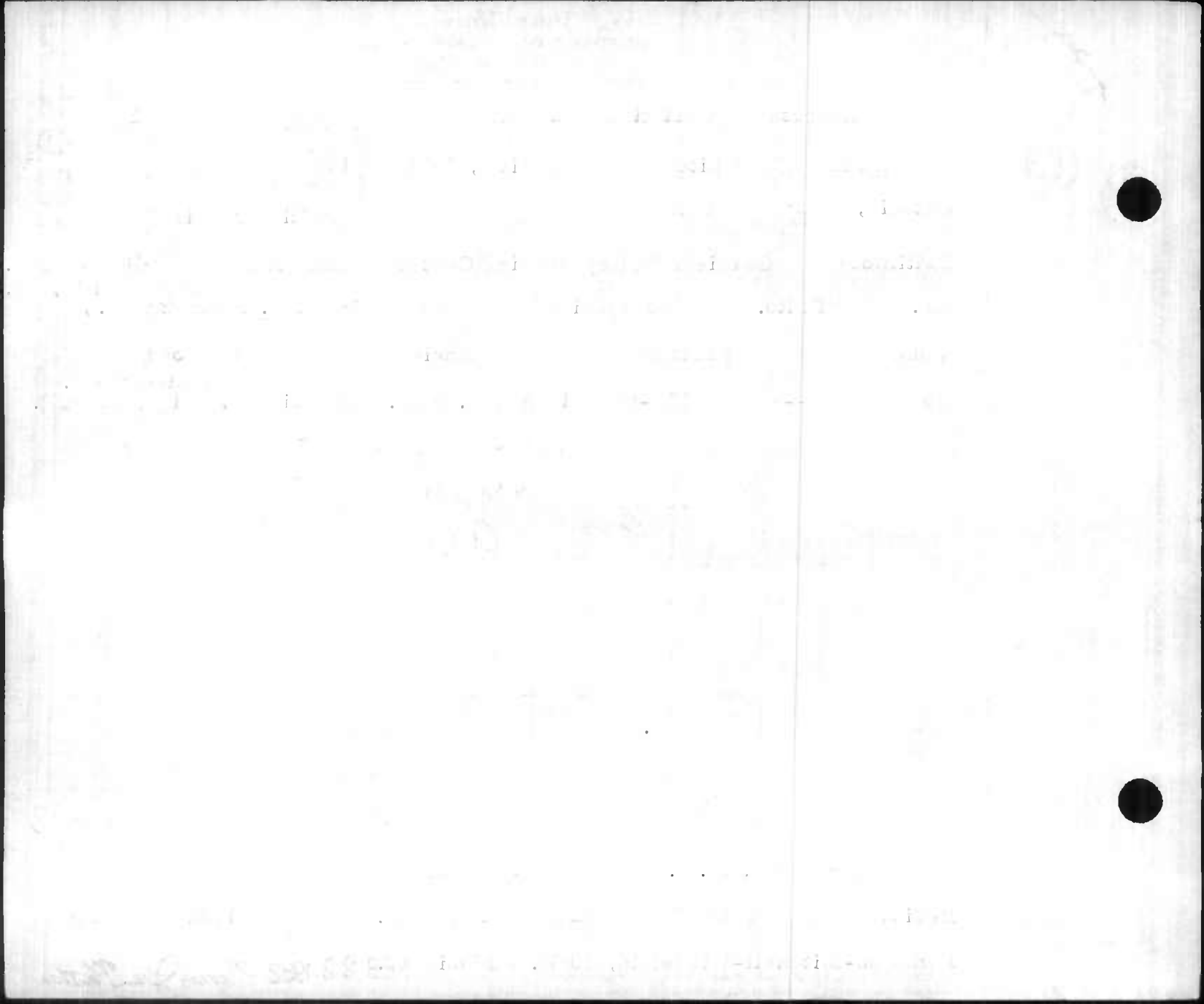
STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 2 0 3 5 1 0

FOR
1. STATE
REGISTRAR

REG. NO.

| | | | | | |
|---|--|---|---|--|--|
| 1. DECEASED NAME
(TYPE OR PRINT)
FIRST MIDDLE LAST
Alberta Christina Cassell | | | 2a. DATE OF DEATH
MONTH DAY YEAR
February 18, 1982 | | 2b. HOUR
M
 |
| 3. SEX
Female | 4. RACE
White | 5. DATE OF BIRTH
MONTH DAY YEAR
April 4, 1879 | | 6. AGE (IN YEARS LAST BIRTHDAY)
102 YRS | IF UNDER 1 YEAR
MONTHS DAYS
 |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
Ontario, Canada | 7b. CITIZEN OF WHAT COUNTRY?
USA | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
Baltimore City MD. | |
| 10. CITY OR TOWN OF DEATH
Baltimore | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
Garrison Valley Nursing Center | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
Seamstress | 12b. KIND OF BUSINESS OR INDUSTRY
Tailoring | |
| 13a. STATE
Md. | 13b. COUNTY
Balto. | 13c. CITY OR TOWN
Cockeysville | 13d. INSIDE CITY LIMITS?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | 13e. STREET ADDRESS
Cockeysville, Md.
10312 E. Malcolm Cr., | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
John Eastwood | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
Annie (Unknown) | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
No | 16b. SOCIAL SECURITY NO.
(IF YES, GIVE WAR OR DATES)
215-01-6114 | 17. INFORMANT
ADDRESS
Malcolm Cr.
Mr. & Mrs. Frederick C. Bliss, 10312 E. | | | |
| 18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Cerebro pulmonary aneurysm
4292
DUE TO, OR AS A CONSEQUENCE OF (b) ASCVD
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last }
DUE TO, OR AS A CONSEQUENCE OF (c) AGE
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
Years | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input type="checkbox"/> | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) | |
| 21d. INJURY OCCURRED
WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | |
| 22a. I certify that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) last saw the deceased alive on _____, 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | |
| 22b. SIGNATURE
Lawrence Boas | | DEGREE
M.D. | | 22c. DATE SIGNED
Feb 22, 82 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
Lawrence Boas, M.D. | | 22e. ADDRESS
50 Scott Adam Road | | | |
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)
Burial | 23b. DATE
2/22/82 | 23c. NAME OF CEMETERY OR CREMATORY
Dulaney Valley Cem. | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
Cockeysville, Maryland | |
| 24. FUNERAL DIRECTOR
NAME ADDRESS
Lemmon-Mitchell-Wiedefeld, 10 W. Padonia Rd. | | 25a. DATE REC'D. BY REGISTRAR
FEB 22 1982 | | 25b. REGISTRAR'S SIGNATURE
James Van Natta | |



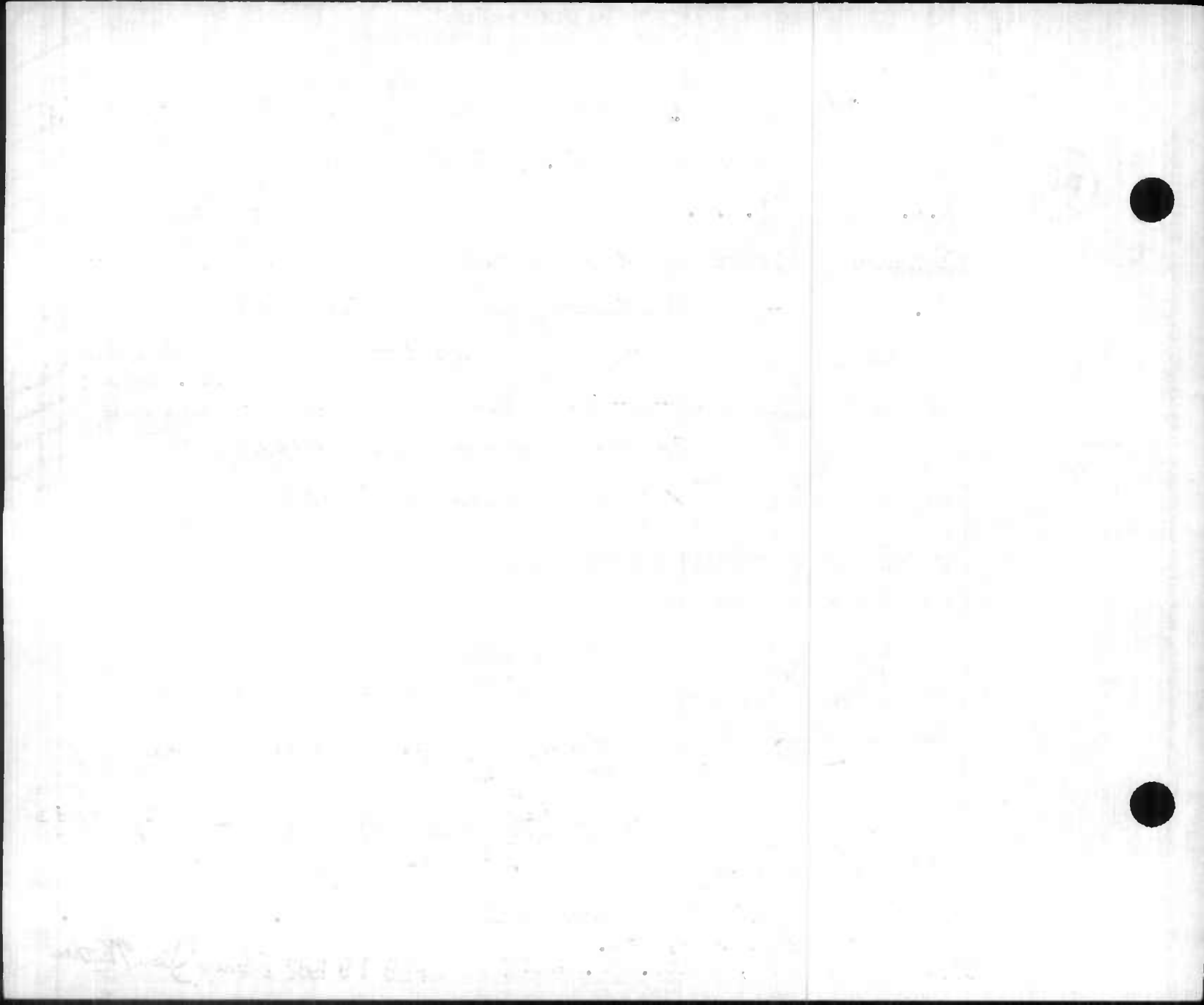
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers (pages 1 and 2) and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified and a post-mortem examination required.

MEDICAL CERTIFICATION

| STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH | | | | | | | | | |
|---|--|---|--|---|---|---|--|--|--|
| 1. FOR STATE REGISTRAR | | | | | 8 2 0 3 6 1 1
REG. NO. | | | | |
| 1. DECEASED NAME (TYPE OR PRINT)
FIRST MARY MIDDLE E. LAST CASTNER | | | | | 2a. DATE OF DEATH MONTH DAY YEAR
2/17/82 | | | 2b. HOUR
4:10 AM | |
| 3. SEX
Female | | 4. RACE
Caucasian | | 5. DATE OF BIRTH MONTH DAY YEAR
Feb. 3 1906 | | 6. AGE (IN YEARS (LAST BIRTHDAY))
76 | | IF UNDER 1 YEAR
MONTHS DAYS HOURS MIN. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
N.J. | | 7b. CITIZEN OF WHAT COUNTRY?
U.S.A. | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
Baltimore City MD | | | |
| 10. CITY OR TOWN OF DEATH
Baltimore | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
Baltimore City Hospital | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)
Homemaker | | 12b. KIND OF BUSINESS OR INDUSTRY
- | |
| 13a. STATE
Md. | | 13b. COUNTY
- | | 13c. CITY OR TOWN
Baltimore | | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS
1233 Frailey Way | |
| 14. FATHER'S NAME FIRST MIDDLE LAST
Samuel - Pharo | | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST
Harriet Simpkins | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)
no | | 16b. SOCIAL SECURITY NO.
213-28-4620 | | 17. INFORMANT ADDRESS
Gaynel Mangus (friend) 1225 Frailey Way | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART 1. DEATH WAS CAUSED BY
4100 IMMEDIATE CAUSE (a) <u>CARDIO RESPIRATORY ARREST</u>
DUE TO, OR AS A CONSEQUENCE OF
(b) <u>MYOCARDIAL INFARCT</u>
DUE TO, OR AS A CONSEQUENCE OF
(c) _____
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) _____ | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | | | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK AT WORK | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 2/13 19 82 to 2/17 19 82, that (I) (we) last saw the deceased alive on 2/17 19 82, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death. | | | | | | | | | |
| 27b. SIGNATURE
Mary Snoble MD | | | | | | | | 27c. DATE SIGNED
2/17/82 | |
| 27a. PHYSICIAN'S NAME (TYPE OR PRINT)
Mary STRACKL | | | | 27e. ADDRESS
Balto City Hospital | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)
Burial | | 23b. DATE
2/19/82 | | 23c. NAME OF CEMETERY OR CREMATORY
Holly Hill | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
Balto. Md. | | | |
| 24. SCHIMUNEK FUNERAL HOME, INC.
3331 Brehms Lane, Balto. Md. 21213 | | | | | | 25a. DATE REC'D. BY REGISTRAR
FEB 19 1982 | | 25b. REGISTRAR'S SIGNATURE
James J. VanNathan | |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial permit. Then please remove carbon paper and return page 1 and 2 to be filed in the office of the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

DHMH - 16 50M 1/81
(VRA 15, 4)

| STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH | | | | | | | | | | 8 2 0 3 5 1 2 | | | |
|---|--|--|--|---|--|---|--|---|--|--|-----|------|----------|
| 1. FOR STATE REGISTRAR | | REG. NO. | | | | | | | | | | | |
| 1. DECEASED NAME (TYPE OR PRINT) | | FIRST | | MIDDLE | | LAST | | 2a. DATE OF DEATH | | MONTH | DAY | YEAR | 2b. HOUR |
| FRED | | J. | | CASTRILLI | | FEBRUARY 15, 1982 | | 2:08P | | | | M | |
| 3. SEX | | 4. RACE | | 5. DATE OF BIRTH | | 6. AGE (IN YEARS LAST BIRTHDAY) | | IF UNDER 1 YEAR | | IF UNDER 24 HRS | | | |
| Male | | White | | Nov. 4, 1914 | | 67 | | YRS | | MONTHS | | DAYS | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) | | 7b. CITIZEN OF WHAT COUNTRY? | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH | | BALTIMORE CITY | | MD. | | | |
| Maryland | | U.S.A. | | | | BALTIMORE CITY | | | | | | | |
| 10. CITY OR TOWN OF DEATH | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | | 12b. KIND OF BUSINESS OR INDUSTRY | | Agent Rep. American Ship Ser. | | | | | |
| Baltimore | | JOHNS HOPKINS HOSPITAL | | | | | | | | | | | |
| 13a. STATE | | 13b. COUNTY | | 13c. CITY OR TOWN | | 13d. INSIDE CITY LIMITS? | | 13e. STREET ADDRESS | | Balt., Md. 21206 | | | |
| Maryland | | | | Baltimore | | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 5803 Arizona Avenue | | | | | |
| 14. FATHER'S NAME | | 15. MOTHER'S MAIDEN NAME | | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) | | 16b. SOCIAL SECURITY NO. | | 17. INFORMANT | | Wife: Balt., Md. 21206 | | | |
| Raphael | | Helen | | No | | 213-10-2321 | | Loriene C. Castrilli | | 5803 Arizona Ave. | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: | | IMMEDIATE CAUSE (a) | | 2028 | | DUE TO, OR AS A CONSEQUENCE OF | | Respiratory Arrest | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | | |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. | | (b) | | Lymphoma | | DUE TO, OR AS A CONSEQUENCE OF | | | | | | | |
| (c) | | | | | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (d) | | | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? | | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | YES <input type="checkbox"/> NO <input type="checkbox"/> | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | | | | | | | |
| 21d. INJURY OCCURRED | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION | | CITY OR TOWN | | COUNTY | | STATE | | | |
| 22a. I certify that (this hospital) attended the deceased from 2/15, 1982, to 2/15, 1982, that (I) (we) lost the deceased alive on 2/15, 1982, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death. | | | | | | | | | | | | | |
| 22b. SIGNATURE | | DEGREE | | 22c. DATE SIGNED | | 22d. PHYSICIAN'S NAME (TYPE OR PRINT) | | 22e. ADDRESS | | | | | |
| P. Richman | | M.D. | | 2/15/82 | | PAUL RICHMAN | | Johns Hopkins Hospital | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) | | 23b. DATE | | 23c. NAME OF CEMETERY OR CREMATORY | | 23d. LOCATION | | COUNTY | | STATE | | | |
| Burial | | Feb 19 1981 | | Holy Redeemer Cem. | | Baltimore | | Maryland | | | | | |
| 24. FUNERAL DIRECTOR | | 25a. DATE RECD. BY REGISTRAR | | 25b. REGISTRAR'S SIGNATURE | | | | | | | | | |
| Leonard J. Ruck, Inc. | | Baltimore, Maryland | | FEB 18 1981 | | | | | | | | | |

BP

1944-1945

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. It may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filled within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

DHMH-16 30M 2/80
(VRA 15, 4)1. FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | | | |
|---|--|--|---|---|--|---|--|------------------------------------|--|
| 1. DECEASED NAME
(TYPE OR PRINT) JOSEPH THOMAS CAVEY | | | 2a. DATE OF DEATH MONTH DAY YEAR 2 14 82 | | | 2b. HOUR 12:45 A | | | |
| 3. SEX
Male | | 4. RACE
White | | 5. DATE OF BIRTH
MONTH DAY YEAR
10 6 09 | | 6. AGE (IN YEARS LAST BIRTHDAY)
72 YRS. | | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
Maryland | | 7b. CITIZEN OF WHAT COUNTRY?
U.S.A. | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
BALTIMORE CITY MD. | | | |
| 10. CITY OR TOWN OF DEATH
Baltimore | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
North Charles Hospital | | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
Railroad | | 12b. KIND OF BUSINESS OR INDUSTRY
B & O Railroad | | |
| 13a. STATE
Maryland | | | | 13b. COUNTY
A.A. Co. | | 13c. CITY OR TOWN
Glen Burnie | | | |
| 13d. INSIDE CITY LIMITS?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | 13e. STREET ADDRESS
6660 Shelly Road 21061 | | | | | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
Joseph A. Cavey, Sr. | | | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
Sophia Rapp | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
YES | | 16b. SOCIAL SECURITY NO.
(IF YES, GIVE WAR OR DATES)
WW II | | 17. INFORMANT ADDRESS
Florence M. Cavey 6660 Shelly Road 21061 | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) CA of Colon & Liver metastases
1539
DUE TO, OR AS A CONSEQUENCE OF
(b) _____
DUE TO, OR AS A CONSEQUENCE OF
(c) _____
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost: _____ | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
Sev. months | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2) | | | | | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 2/12 , 19 82 , to 2/14 , 19 82 , that (I) (we) last saw the deceased alive on 2/14 , 19 82 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | 22c. DATE SIGNED
2/14/82 | |
| 22b. SIGNATURE
Veneranda G. Barnes | | | | DEGREE
M.D. | | | | 22c. DATE SIGNED
2/14/82 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
VENERANDA G. BARNES | | | | 22e. ADDRESS
NORTH CHARLES GEN. HOSPO. | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)
Burial | | 23b. DATE
2/18/82 | | 23c. NAME OF CEMETERY OR CREMATORY
Crownsville Vet. Cem. | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
Crownsville A.A. Co. Md. | | | |
| 24. FUNERAL DIRECTOR
NAME ADDRESS
Hubbard Funeral Home, Inc. 4107 Wilkens Ave. 21229 | | | | 25a. DATE REC'D. BY REGISTRAR
FEB 19 1982 | | 25b. REGISTRAR'S SIGNATURE
Frances Jean Nathan | | | |

MEDICAL CERTIFICATION

BP



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

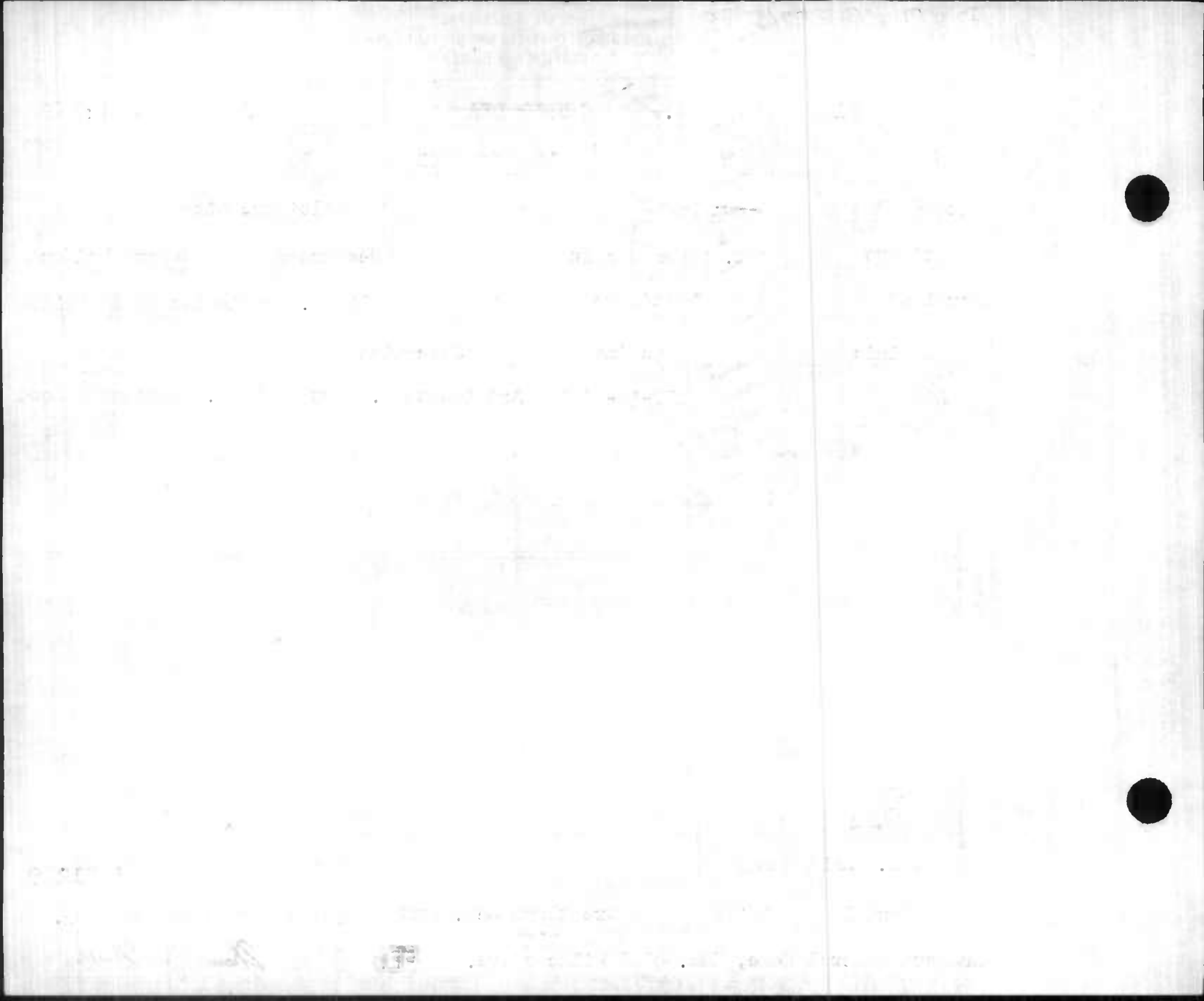
Item 7b g564 2/17/82 gj

1 - STATE REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | | | | | | |
|---|--|---|--|---|---|--|--|--|---|---|--|--|
| 1. DECEASED NAME
(TYPE OR PRINT)
FIRST MARY MIDDLE D. LAST CERNIGLIA | | | 2a. DATE OF DEATH
MONTH DAY YEAR
2 2 82 | | 2b. HOUR
1:35 P.M. | | | | | | | |
| 3. SEX
F | | 4. RACE
W | | 5. DATE OF BIRTH
MONTH DAY YEAR
12 22 03 | | 6. AGE (IN YEARS LAST BIRTHDAY)
78 YRS | | IF UNDER 1 YEAR
MONTHS DAYS | | IF UNDER 24 HRS
HOURS MIN. | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
Italy | | 7b. CITIZEN OF WHAT COUNTRY?
NO Italy | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
Baltimore City MD. | | | | | | |
| 10. CITY OR TOWN OF DEATH
Baltimore | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
St. Agnes Hospital | | | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
Seamstress | | | 12b. KIND OF BUSINESS OR INDUSTRY
Howard Uniform | | | |
| 13a. STATE
Maryland | | | | 13b. COUNTY
Baltimore | | 13c. CITY OR TOWN
Baltimore | | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS
735 S. Woodington Road 21229 | | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
Dominic Defina | | | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
Josephine unknown | | | | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
NO | | | | |
| 16b. SOCIAL SECURITY NO.
(IF YES, GIVE WAR OR DATES)
217-18-9651 | | | | 17. INFORMANT
ADDRESS
21229
Antoinette M. Barth 735 S. Woodington Road | | | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))
PART 1. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>Cardiopulmonary Failure</u>
1539
DUE TO, OR AS A CONSEQUENCE OF
(b) <u>generalized metastasis of colon carcinoma</u> 2 yrs
DUE TO, OR AS A CONSEQUENCE OF
(c) _____
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1. a | | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER NOTIFY MEDICAL EXAMINER) | | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | | | | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK | | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | | | | |
| 22a. I certify that Dr. Hsin Peng attended the deceased from <u>Feb. 1</u> , 19 <u>82</u> , to <u>Feb. 2</u> , 19 <u>82</u> , that (1) was last saw the deceased alive on <u>Feb. 2</u> , 19 <u>82</u> , and that in (my) best opinion death occurred on the date and hour and from the causes stated above, (1) we (did) (did not) view the body after death. | | | | | | | | | | | | |
| 22b. SIGNATURE
<u>Hsin Peng M.D.</u> | | | | | | DEGREE
ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> | | 22c. DATE SIGNED
<u>Feb. 2 1982</u> | | | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
DR. Hsin Peng | | | | | | 22e. ADDRESS
900 CATON AVENUE BALTIMORE, MD 21229 | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)
Burial | | | 23b. DATE
2/5/82 | | 23c. NAME OF CEMETERY OR CREMATORY
Crestlawn Mem. Park | | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
Marriottsville Howard Md. | | | | |
| 24. FUNERAL DIRECTOR
NAME
Hubbard Funeral Home, Inc. 4107 Wilkens Ave. | | | | | | 25a. DATE REC'D. BY REGISTRAR
FEB 3 1982 | | 25b. REGISTRAR'S SIGNATURE
<u>Thomas J. Smith</u> | | | | |



TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITH PAGES 3 AND 4, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

MEDICAL CERTIFICATION

| STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH | | | | | | | | | | REG. NO. 2 03615 | |
|--|--|------------------|--|---|--|---|--|--|-----------------------|--|--|
| 1- FOR STATE REGISTRAR | | | | | | | | | | | |
| 1. DECEASED NAME (TYPE OR PRINT)
FIRST MIDDLE LAST
Jerry K. Cerny | | | | | | 2a. DATE KNOWN OF DEATH
ESTIMATED <input checked="" type="checkbox"/> MONTH DAY YEAR
2 3 1982 | | | 2b. HOUR
M
a.m. | | |
| 3. SEX
Male | | 4. RACE
White | | 5. DATE OF BIRTH
MONTH DAY YEAR
10-4-1895 | | 6. AGE (IN YEARS)
(LAST BIRTHDAY)
86 YRS. | | IF UNDER 1 YR.
MONTHS DAYS | | IF UNDER 24 HRS.
HOURS MIN. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
MARYLAND | | | | 7b. CITIZEN OF WHAT COUNTRY?
U.S.A. | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
Baltimore City, MD. | | | |
| 10. CITY OR TOWN OF DEATH
Baltimore | | | | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
733 N. Chester Street | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)
CARPENTER | | 12b. KIND OF BUSINESS OR INDUSTRY
CONSTRUCTION | |
| USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) | | | | | | | | | | | |
| 13a. STATE
MD. | | 13b. COUNTY
— | | 13c. CITY OR TOWN
BALTO. | | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS
733 N. CHESTER ST. | | | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
JOHN CERNY | | | | | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
MARIA POKORNA | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO, OR UNKNOWN)
No | | | | 16b. SOCIAL SECURITY NO.
(IF YES, GIVE WAR OR DATES)
— | | 17. INFORMANT ADDRESS
Mrs. Carol Hill - 2510 South Rd. - Cincinnati Ohio | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I DEATH WAS CAUSED BY:
4292 IMMEDIATE CAUSE (a) Arteriosclerotic Cardiovascular Disease
(b) DUE TO, OR AS A CONSEQUENCE OF
(c) DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause lost. | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | | | | | | 20. AUTOPSY?
(head only)
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. EXTERNAL CAUSE WAS
UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH | | | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) | | | | | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/> | | | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) | | 21f. LOCATION
CITY OR TOWN COUNTY STATE | | | | | |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> . | | | | | | | | | | | |
| ACTUAL SIGNATURE Virginia L. Dolan | | | | | | TITLE (SPECIFY)
M.D. Assistant | | MEDICAL EXAMINER | | DATE SIGNED 2-3-82 | |
| EXAMINER'S NAME (TYPE OR PRINT) Virginia L. Dolan, M.D. | | | | | | ADDRESS 111 Penn Street | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)
BURIAL | | | | 23b. DATE
2-6-82 | | 23c. NAME OF CEMETERY OR CREMATORY
OAK LAWN Cem. | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
BALTO. MD. | | | |
| 24. FUNERAL DIRECTOR
NAME
Hartley Miller - 2334 Jefferson St. | | | | | | 25a. DATE REC'D. BY REGISTRAR
FEB 5 1982 | | 25b. REGISTRAR'S SIGNATURE
Hans J. [Signature] | | | |

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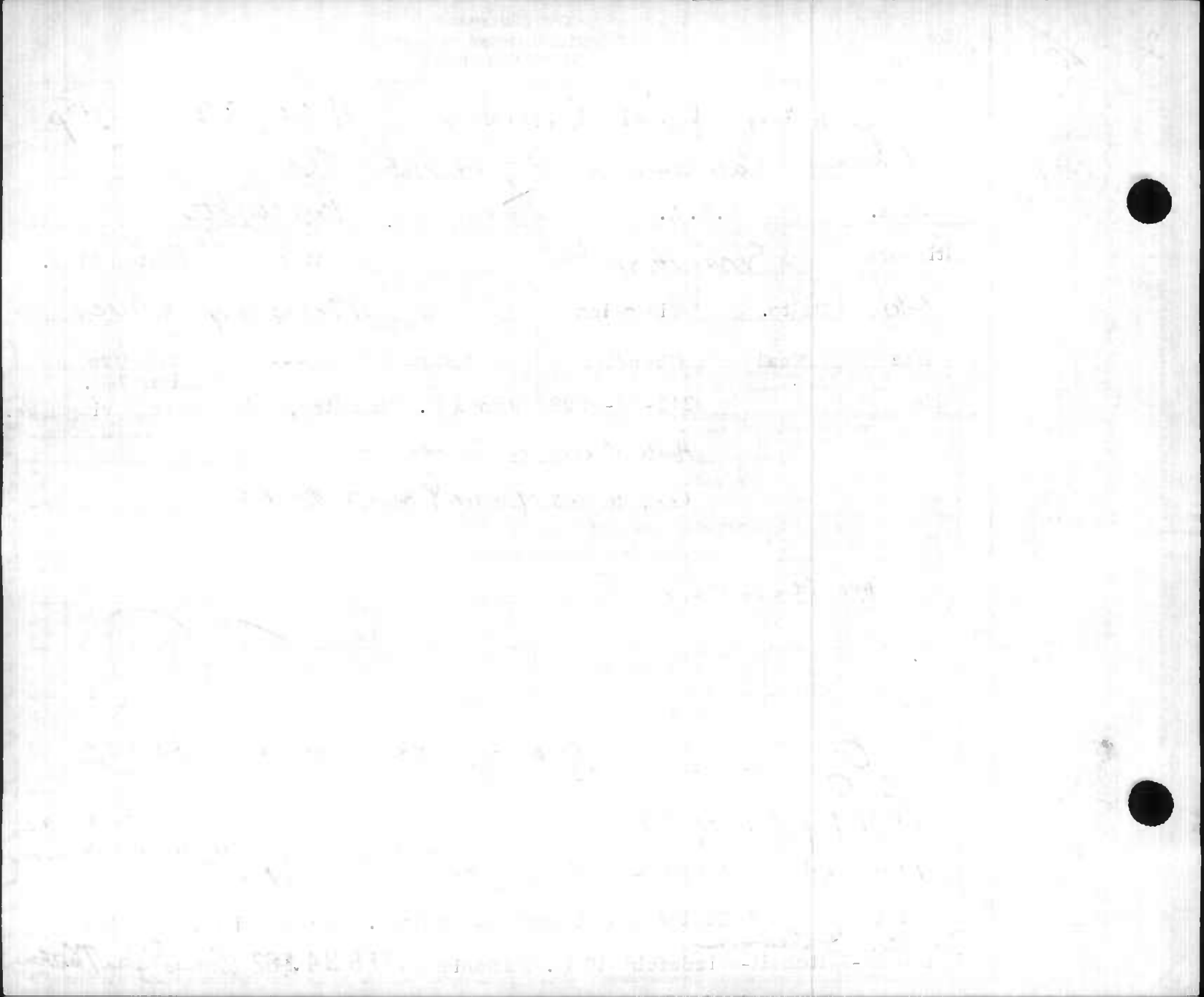
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STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 2 0 3 0 1 0

| | | | |
|---|---|--|---|
| 1 - FOR STATE REGISTRAR | | REG. NO. | |
| 1. DECEASED NAME (TYPE OR PRINT)
FIRST MIDDLE LAST
LOVELYN WILLIAM CHANDLER | | 2a. DATE OF DEATH MONTH DAY YEAR
2/20/82 2b. HOUR
6:45 P.M. | |
| 3. SEX
Male | 4. RACE
Caucasian | 5. DATE OF BIRTH MONTH DAY YEAR
9-14-1905 | |
| 6. AGE (IN YEARS LAST BIRTHDAY)
76 YRS. | 7. BALTIMORE CITY OR COUNTY OF DEATH
Balto. City MD. | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |
| 9. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
Penna. | 10. CITY OR TOWN OF DEATH
Baltimore | 11. NAME OF HOSPITAL NURSING HOME OR OTHER INSTITUTION (NOT IN SUGH FACILITY GIVE STREET ADDRESS)
Sinai Hospital | |
| 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)
Auditor | 12b. KIND OF BUSINESS OR INDUSTRY
State of Md. | | |
| 13a. STATE
Md. | 13b. COUNTY
Balto. | 13c. CITY OR TOWN
Timonium | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 14. FATHER'S NAME FIRST MIDDLE LAST
Asa Neal Chandler | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST
Laura --- Breasure | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)
No | 16b. SOCIAL SECURITY NO.
212-03-9008 | 17. INFORMANT ADDRESS
Rhoda H. Chandler, 11763 Green Spring Ave. Timonium Md. | |
| 18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) 4100 Acute Myocardial Infarction
DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Long History of Coronary Artery Disease
DUE TO, OR AS A CONSEQUENCE OF (c) _____
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH _____ | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) Two Previous MI's | | | |
| 19a. DATE OF OPERATION | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR
P.M. 19 | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) | |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | |
| 22a. I certify that (I) (this hospital) attended the deceased from Feb 20, 1982 to Feb 20, 1982 , that (I) (we) last saw the deceased alive on Feb 20, 1982 , and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death. | | | |
| 22b. SIGNATURE
Philip Jay Schwartz MD | | DEGREE
MD | 22c. DATE SIGNED
Feb 20, 1982 |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
PHILIP JAY SCHWARTZ MD | | 22e. ADDRESS
SINAI HOSPITAL Dept of Intern Medicine BALTIMORE, MD 21215 | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)
Burial | 23b. DATE
2/24/1982 | 23c. NAME OF CEMETERY OR CREMATORY
Dulaney Valley Cem. | 23d. LOCATION CITY OR TOWN COUNTY STATE
Cockeysville, Maryland |
| 24. FUNERAL DIRECTOR
Lemmon-Mitchell-Wiedefeld | | 25a. DATE REC'D. BY REGISTRAR
FEB 24 1982 | |
| 25b. REGISTRAR'S SIGNATURE
Charles Jean Nathan | | | |

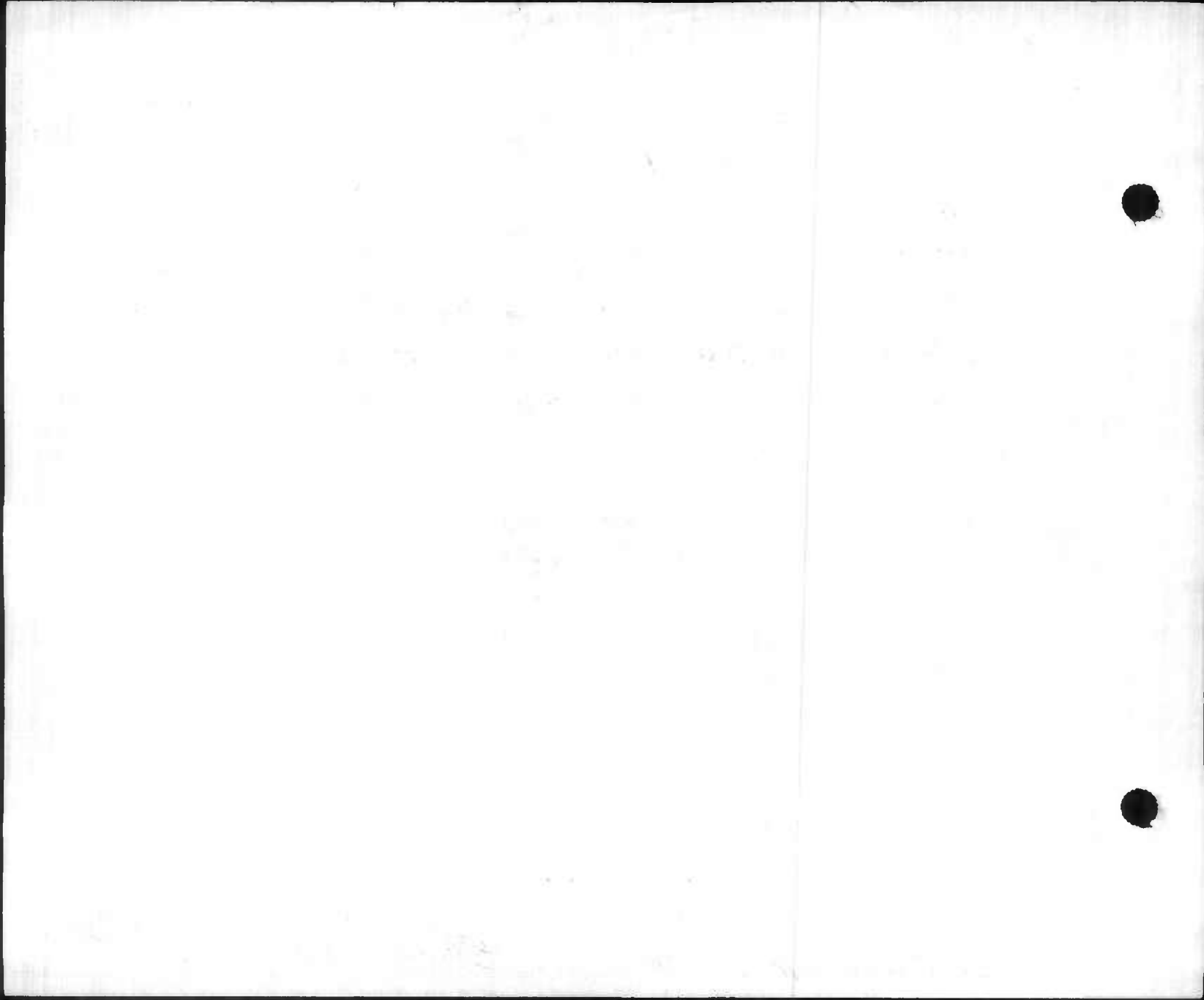


TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 1b. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM-3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | | | | | | | | | | | | | |
|--|--|--|--|--|--|--|--|---|--|--|--|--|--|---|--|---------------------------------|--|--|--|
| 1. DECEASED NAME
(TYPE OR PRINT) | | 3. SEX
male | | 4. RACE
black | | 5. DATE OF BIRTH
MONTH DAY YEAR
1 30 31 51 | | 6. AGE (IN YEARS)
(LAST BIRTHDAY)
51 YRS. | | IF UNDER 1 YR.
MONTHS DAYS HOURS MIN. | | IF UNDER 24 HRS.
MONTHS DAYS HOURS MIN. | | 7a. DATE KNOWN OF DEATH
ESTI-MATED
2-25-82 ₁₉ | | 7b. HOUR
M
P _M | | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
Md | | 7b. CITIZEN OF WHAT COUNTRY?
USA | | 8. MARRIED
WIDOWED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
Baltimore City MD | | | | | | | | | | | | | |
| 10. CITY OR TOWN OF DEATH
Baltimore | | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
Provident Hospital | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)
Meat Cutter | | | | 12b. KIND OF BUSINESS OR INDUSTRY
Civil Service | | | | | | | | | |
| 13a. STATE
Md | | | | 13b. COUNTY | | 13c. CITY OR TOWN
Baltimore | | 13d. INSIDE (CITY LIMITS)?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS
3703 Chesholm Rd | | | | | | | | | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
James Arthur Chatman | | | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE
Florence Porter | | | | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO, OR UNKNOWN)
No | | | | | | | | | | | |
| 16b. SOCIAL SECURITY NO.
216-22-4346 | | | | 17. INFORMANT
ADDRESS 3703
Mrs Florence C. Rice Chesholm Rd | | | | | | | | | | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Arteriosclerotic cardiovascular disease
4292 } DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. (b) }
DUE TO, OR AS A CONSEQUENCE OF (c) } | | | | | | | | | | | | | | | | | | | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a). | | | | | | | | | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | | | | | | | | | | 20. AUTOPSY?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | | | |
| 21a. EXTERNAL CAUSE WAS
UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH | | | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2) | | | | | | | | | | | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK AT WORK | | | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) | | | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | | | | | | | | | |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> . Inspection <input type="checkbox"/> . Inquiry <input type="checkbox"/> . and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> . Accident <input type="checkbox"/> . Suicide <input type="checkbox"/> . Homicide <input type="checkbox"/> . Undetermined manner <input type="checkbox"/> . | | | | | | | | | | | | | | | | | | | |
| ACTUAL SIGNATURE
Margaret A. Koroll | | | | TITLE (SPECIFY)
M.D. Assistant MEDICAL EXAMINER | | | | | | | | | | DATE SIGNED
2-26-82 | | | | | |
| EXAMINER'S NAME
(TYPE OR PRINT)
Margaret A. Koroll, M.D. | | | | ADDRESS
111 Penn Street | | | | | | | | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)
Cremation | | | | 23b. DATE
2/27/82 | | | | 23c. NAME OF CEMETERY OR CREMATORY
Westview Mem. Pk | | | | 23d. LOCATION
(CITY OR TOWN) COUNTY STATE
Catonsville Baltimore Md | | | | | | | |
| 24. FUNERAL DIRECTOR
NAME
Chatman | | | | ADDRESS
1701 McCulloch St | | | | 25a. DATE REC'D BY REGISTRAR
MAR 1 1982 | | | | 25b. REGISTRAR'S SIGNATURE
James J. Smith | | | | | | | |



STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8-2 03518

1- FOR
STATE
REGISTRAR

REG. NO.

| | | | | | | | | | | | |
|--|--|--|--|---|--|--|---|--|-----------------------------|--------------------------------|--|
| 1. DECEASED NAME
(TYPE OR PRINT)
FIRST MIDDLE LAST
Melvin V. B. Chilcoat | | | 2a. DATE OF DEATH
MONTH DAY YEAR
2-22-82 | | 2b. HOUR A M
8:30 A | | | | | | |
| 3. SEX
Male | | 4. RACE
White | | 5. DATE OF BIRTH
MONTH DAY YEAR
June 12, 1896 | | 6. AGE (IN YEARS LAST BIRTHDAY)
85 YRS. | | IF UNDER 1 YEAR
MONTHS DAYS | | IF UNDER 24 HRS.
HOURS MIN. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
Maryland | | 7b. CITIZEN OF WHAT COUNTRY?
USA | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
Baltimore City MD. | | | | | |
| 10. CITY OR TOWN OF DEATH
Baltimore | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
Jenkins Memorial Home
1000 S. Caton Ave. 21229 | | | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
Salesman | | 12b. KIND OF BUSINESS OR INDUSTRY | | | |
| 13a. STATE
Maryland | | 13b. COUNTY
Baltimore | | 13c. CITY OR TOWN
Catonsville | | 13d. INSIDE CITY LIMITS?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 13e. STREET ADDRESS
4313 A. Wilkens Avenue | | | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
Thomas Melvin Chilcoat | | | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
Lida Morris | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
No | | 16b. SOCIAL SECURITY NO.
216 03 3545 | | 17. INFORMANT
Mrs. J. M. Hughes, Balto., Md. | | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line (a), (b), and (c).
PART I. DEATH WAS CAUSED BY
IMMEDIATE CAUSE (a) <u>Cardiac Arrhythmia</u>
4292
DUE TO, OR AS A CONSEQUENCE OF
(b) <u>Asphyxiation</u>
DUE TO, OR AS A CONSEQUENCE OF
(c) <u>Pneumonia</u>
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last | | | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | | | |
| 21d. INJURY OCCURRED
WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | | | |
| 22a. I certify that (1) (this hospital) attended the deceased from <u>2-26-81</u> , 19 <u>81</u> , to <u>2-22-82</u> , 19 <u>82</u> , that (1) (we) lost
saw the deceased alive on <u>2-22-82</u> , 19 <u>82</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated
above; (1) (we) did (did not) view the body after death. | | | | | | | | | | | |
| 22b. SIGNATURE
<u>George B. Novak</u> | | | DEGREE | | | ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> | | | 22c. DATE SIGNED
2-22-82 | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
GEORGE B. NOVAK | | | 22e. ADDRESS
3350 Wilkens Dr. Balto | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)
Burial | | | 23b. DATE
2/25/82 | | 23c. NAME OF CEMETERY OR CREMATORY
Wiseburg | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
Wiseburg, Md. | | | | |
| 24. FUNERAL DIRECTOR
NAME
Henry W. Jenkins & Sons Co.
4905 York Road Balto., Md. 21212 | | | 25a. DATE REC'D. BY REGISTRAR
FEB 23 1982 | | | 25b. REGISTRAR'S SIGNATURE
<u>James J. Smith</u> | | | | | |

MEDICAL CERTIFICATION

1948

1949

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1958

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 2 0 3 6 1 9

1. FOR
STATE
REGISTRAR

REG. NO.

| | | | | | | | |
|---|--|--|--|---|-----------------------------------|---|--|
| 1. DECEASED NAME
(TYPE OR PRINT) GAYNELL CHRISTIANSEN | | | 2a. DATE OF DEATH
MONTH DAY YEAR
02/17/82 | | 2b. HOUR
MIN.
9:09 A | | |
| 3. SEX
FEMALE | | 4. RACE
CAUCASIAN | | 5. DATE OF BIRTH
MONTH DAY YEAR
07/23/66 | | 6. AGE (IN YEARS LAST BIRTHDAY)
YRS MONTHS DAYS
15 | |
| 7a. BIRTHPLACE
(COUNTRY) OKLAHOMA | | 7b. CITIZEN OF WHAT COUNTRY?
U.S.A | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
Baltimore City MD. | |
| 10. CITY OR TOWN OF DEATH
Baltimore | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
THE JOHNS HOPKINS HOSPITAL | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
STUDENT | | 12b. KIND OF BUSINESS OR INDUSTRY
HIGH SCHOOL | |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)
STATE COUNTY
Virginia Fairfax | | 13c. CITY OR TOWN
Annandale | | 13d. INSIDE CITY LIMITS?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 13e. STREET ADDRESS
4304 Roberts Avenue | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
Valor Christiansen | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
Janet Layton | | 16. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN) NO | | | |
| 16b. SOCIAL SECURITY NO.
228170962 | | 17. INFORMANT Father ADDRESS 4304 Roberts Avenue
Valor Christiansen-Annandale, Va. | | | | | |

| | | |
|---|--|---|
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Cytomegalovirus pneumonia
2050
DUE TO, OR AS A CONSEQUENCE OF
(b) Bone Marrow Transplantation
DUE TO, OR AS A CONSEQUENCE OF
(c) Acute Myelogenous Leukemia | | APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATH |
|---|--|---|

| | | | |
|---|--|---|--|
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)
None. | | | |
| 19a. DATE OF OPERATION
1/12/82 | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED
None. | |
| 20a. AUTOPSY?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED
IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
19 | |
| 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1B, PART I OR PART 2)
None. | | 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK AT WORK | |
| 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)
None. | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE
None. | |
| 22a. I certify that (I) (this hospital) attended the deceased from 11/29 , 19 81 , to 02/17 , 19 82 , that (if <input checked="" type="checkbox"/>) last
saw the deceased alive on 02/17 , 19 82 , and that (in <input checked="" type="checkbox"/>) (my) (our) opinion death occurred on the date and hour and from the causes stated
above, (I) (we) (did) (did not) view the body after death. | | | |
| 22b. SIGNATURE
Ferry A. Boulware M.D. | | 22c. DATE SIGNED
02/19/82 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
Ferry A. Boulware M.D. | | 22e. ADDRESS
601 N Broadway (The Johns Hopkins Hosp) | |

| | | | | | | | |
|--|--|-----------------------------|--|--|--|---|--|
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY) Burial | | 23b. DATE
2-23-82 | | 23c. NAME OF CEMETERY OR CREMATORY
Browns Mill Cem. | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
Browns Mill, Pa. | |
| 24. FUNERAL DIRECTOR
NAME ADDRESS
Colonial Funeral Home-Falls Church, Va. | | | | 25a. DATE REC'D. BY REGISTRAR 25b. REGISTRAR'S SIGNATURE
FEB 25 1982 | | | |

Virginia

Warren Andrew

2000 Columbia Avenue

Valley

Christensen

James

2300000000

James Andrew
2000 Columbia Avenue
Valley Christensen
James Andrew

Butler

2000 22 2000 22 2000 22 2000 22

Colonial Funeral Home Falls Church, Va.

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 4 should be detached for use as the burial-transit permit. Then please remove carbon copies. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH | | | | | | | | | | REG. NO. | |
|--|--|--|--|--|--|--|--|--|--|--|--|
| 1. FOR STATE REGISTRAR | | | | | | | | | | 7a. DATE OF DEATH | |
| 1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST
JOHN CICHOWICZ | | | | | | | | | | MONTH DAY YEAR
02-22-82 | |
| 2a. SEX
Male | | | | | | | | | | 2b. HOUR
8:00pm | |
| 3. RACE
Cauc. | | | | | | | | | | 4. DATE OF BIRTH MONTH DAY YEAR
1 8 1902 | |
| 5. AGE (IN YEARS LAST BIRTHDAY)
80 | | | | | | | | | | 6. IF UNDER 1 YEAR IF UNDER 24 HRS.
MONTHS DAYS HOURS MIN. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
Delaware | | | | | | | | | | 7b. CITIZEN OF WHAT COUNTRY?
U.S.A. | |
| 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | | | | | | | | | 9. BALTIMORE CITY OR COUNTY OF DEATH
Baltimore City MD. | |
| 10. CITY OR TOWN OF DEATH
Baltimore | | | | | | | | | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
Church Hospital | |
| 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)
Pipefitter | | | | | | | | | | 12b. KIND OF BUSINESS OR INDUSTRY
Steel | |
| 13a. STATE
Md. | | | | | | | | | | 13b. COUNTY
Baltimore | |
| 13c. CITY OR TOWN
Baltimore | | | | | | | | | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 13e. STREET ADDRESS
3109 E. Monument St. | | | | | | | | | | | |
| 14. FATHER'S NAME FIRST MIDDLE LAST
Joseph Cichowicz | | | | | | | | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST
Catherine | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)
No | | | | | | | | | | 16b. SOCIAL SECURITY NO.
215-09-4796 | |
| 17. INFORMANT ADDRESS
Clare Cichowicz 3109 Monument St. | | | | | | | | | | | |
| 18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY:
4860 BILATERAL PNEUMONIA WITH | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| IMMEDIATE CAUSE (a) PROBABLE SEPTICEMIA ASSOCIATED WITH HYPOTENSION | | | | | | | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF (b) | | | | | | | | | | | |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. | | | | | | | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF (c) | | | | | | | | | | | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 a:
CONGESTIVE HEART FAILURE, ACUTE RENAL FAILURE | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | | | | | | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | |
| 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | | | | | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | | | | | | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR
P.M. 19 | |
| 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | | | | | | | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/> | | | | | | | | | | 21e. PLACE OF INJURY (AT HOME STREET, FACTORY, OFFICE, FARM, ETC.) | |
| 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | | | | | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 02-15- 19 82 , to 02-22- 19 82 , that (I) (we) last saw the deceased alive on 02-22- 19 82 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | | 22c. DATE SIGNED
2/22/82 | |
| 22b. SIGNATURE A F Nours DEGREE MD | | | | | | | | | | 22c. DATE SIGNED | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) A F Nours | | | | | | | | | | 22e. ADDRESS CHURCH HOSPITAL CORPORATION 100 N. BROADWAY BALTIMORE, MARYLAND 21231 | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)
Burial | | | | | | | | | | 23b. DATE
2/26/82 | |
| 23c. NAME OF CEMETERY OR CREMATORY
St. Stanislaus. | | | | | | | | | | 23d. LOCATION CITY OR TOWN COUNTY STATE
Baltimore Md. | |
| 24. FUNERAL DIRECTOR NAME
B. Dabrowski & Son 2818 E. Baltimore St. | | | | | | | | | | 25a. FILED BY REGISTRAR Feb 23 1982 | |

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TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGES 1, 2, AND 3 IN YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH. WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

| STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH | | | | | | | | | | REG. NO. 7203521 | |
|---|--|---|--|---|--|---|--|---|--|---|--|
| 1. FOR STATE REGISTRAR | | | | | | | | | | | |
| 1. DECEASED NAME
(TYPE OR PRINT) FIRST MIDDLE LAST
Junious Claiborne | | | | | | | | | | 20. DATE KNOWN OF DEATH
ESTIMATED <input checked="" type="checkbox"/> MONTH DAY YEAR
2 15 1982 | |
| 3. SEX
male | | 4. RACE
black | | 5. DATE OF BIRTH
MONTH DAY YEAR
12 24 14 | | 6. AGE (IN YEARS)
LAST BIRTHDAY YRS.
67 | | IF UNDER 1 YR. MONTHS DAYS
XX | | 21. DATE PRONOUNCED DEAD
MONTH DAY YEAR
2 15 1982 | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
VA | | 7b. CITIZEN OF WHAT COUNTRY?
USA | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
Baltimore City | | 12b. KIND OF BUSINESS OR INDUSTRY | | 2d. HOUR
6:14 PM | |
| 10. CITY OR TOWN OF DEATH
Baltimore | | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
2411 Druid Hill Avenue | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)
Retired | | 12b. KIND OF BUSINESS OR INDUSTRY | | | |
| USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) | | | | | | | | | | | |
| 13a. STATE
Md | | 13b. COUNTY
Balto | | 13c. CITY OR TOWN
Balto | | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS
2411 Druid Hill Ave | | | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
Ommie Claiborne | | | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
Bertha Crews | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO, OR UNKNOWN)
Yes | | | | 16b. SOCIAL SECURITY NO.
WW II | | 17. INFORMANT
Alvesta Evans | | ADDRESS
2411 Druid Hill Ave | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Arteriosclerotic cardiovascular disease
4292
DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.
(b) _____
DUE TO, OR AS A CONSEQUENCE OF
(c) _____ | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | | | | 20. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH | | | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) | | | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/> | | | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | | | |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural cause <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> . | | | | | | | | | | | |
| ACTUAL SIGNATURE
Hormez R. Guard, M.D. | | | | TITLE (SPECIFY)
M.D. Assistant | | | | DATE SIGNED
2/16/82 | | | |
| EXAMINER'S NAME (TYPE OR PRINT)
Hormez R. Guard, M.D. | | | | ADDRESS
111 Penn Street, Balto. MD 21201 | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)
Burial | | | | 23b. DATE
22 Feb 82 | | 23c. NAME OF CEMETERY OR CREMATORY
Crownsville Cemetery | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
Crownsville MD | | | |
| 24. FUNERAL DIRECTOR
NAME
Wm C Brown | | | | ADDRESS
1206-08 W. North Ave | | 25a. DATE REC'D. BY REGISTRAR
FEB 18 1982 | | 25b. REGISTRAR'S SIGNATURE
Thane Jan Martin | | | |

W. C. Brown

(1M)

W. C. Brown

W. C. Brown

W. C. Brown

TO HOSPITAL OR ATTENDING PHYSICIAN: The local health officer's death certificate is accepted within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate is accepted by the local health officer, it should be detached for use as the burial-transit permit. Then please send it with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or other disposition of the body.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified and a copy of the report forwarded to the State Dept. of Health and Mental Hygiene.

MEDICAL CERTIFICATION

| | | | | | | | |
|--|--|---|---|---|--------------------------|--|---|
| 1. DECEASED NAME
(TYPE OR PRINT) SAMUEL EDWARD CLANTON | | | 2a. DATE OF DEATH
MONTH DAY YEAR
2-27-82 | | 2b. HOUR
6:38P | | |
| 3. SEX
Male | | 4. RACE
Black | | 5. DATE OF BIRTH
MONTH DAY YEAR
4 25 38 | | 6. AGE (IN YEARS LAST BIRTHDAY)
43 YRS.
IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
N.C. | | 7b. CITIZEN OF WHAT COUNTRY?
USA | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
Baltimore City MD. | |
| 10. CITY OR TOWN OF DEATH
Baltimore | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
John Hopkins Hospital | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE) | | 12b. KIND OF BUSINESS OR INDUSTRY | |
| 13a. STATE
MD | | 13b. COUNTY | | 13c. CITY OR TOWN
Baltimore | | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
Jesse Wilbert Clanton | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
Ruth Kearney | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
No | | 16b. SOCIAL SECURITY NO.
212-34-9803 | | 17. INFORMANT
ADDRESS
Wilbert Clanton 155 West 68th St. | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
4100 IMMEDIATE CAUSE (a) possible myocardial infarction
DUE TO, OR AS A CONSEQUENCE OF
(b) possible coronary artery disease or spasm
DUE TO, OR AS A CONSEQUENCE OF
(c) _____
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
~ 1 HOUR | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
~ 1 HOUR |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a): | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) | | | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK AT WORK | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 2/27/82 6:05P , 19_____, to 2/27/82 6:38P , 19_____, that (I) (we) last saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | |
| 22b. SIGNATURE
Stephen A. Gunnistra | | DEGREE
M.D. | | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> | | 22c. DATE SIGNED
2/27/82 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
STEPHEN GUNNISTRA | | 22e. ADDRESS
JOHN HOPKINS HOSPITAL | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)
Burial | | 23b. DATE
3/3/82 | | 23c. NAME OF CEMETERY OR CREMATORY
Arbutus Mem. Pk. | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
Baltimore Co. MD | |
| 24. FUNERAL DIRECTOR
NAME
Wm. C. March F/H | | | | ADDRESS
1101 E. North Ave. | | 25a. DATE REC'D. BY REGISTRAR
MAR 2 1982 | |
| | | | | 25b. REGISTRAR'S SIGNATURE
James Santhorn | | | |

100

100

100

100

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100

100

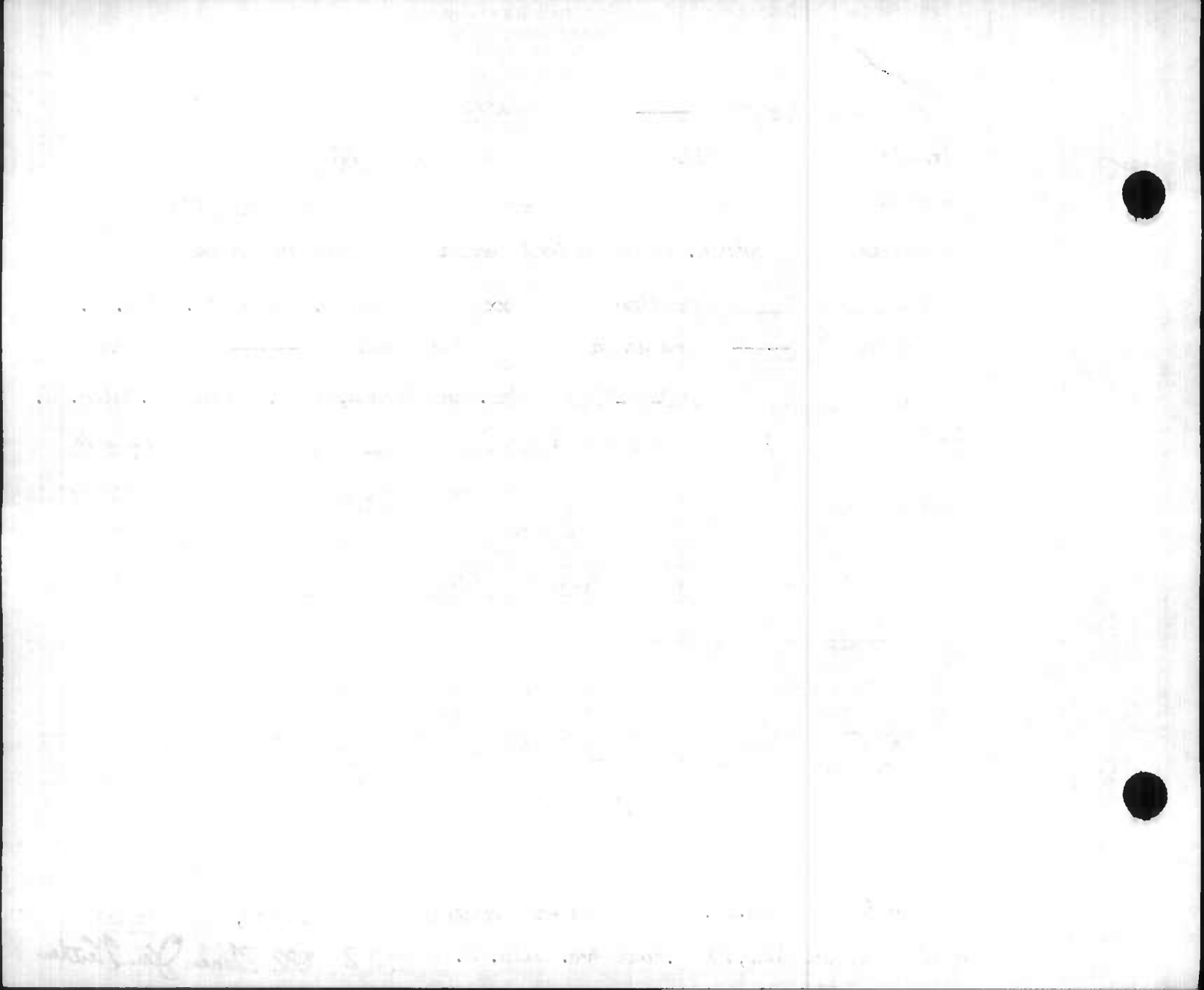
[Faint, illegible handwritten text]

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

MEDICAL CERTIFICATION

| STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH | | | | 8 2 0 3 6 2 3 | | | |
|--|--|---|--|---|--|--|--|
| 1. FOR STATE REGISTRAR | | | | REG. NO. | | | |
| 1. DECEASED NAME
(TYPE OR PRINT) MARGARET CLARK | | | | 2a. DATE OF DEATH
MONTH DAY YEAR
2 24 82 | | 2b. HOUR
8:50 P.M. | |
| 3. SEX
Female | | 4. RACE
White | | 5. DATE OF BIRTH
MONTH DAY YEAR
10 9 1893 | | 6. AGE (IN YEARS LAST BIRTHDAY)
88 | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
Maryland | | 7b. CITIZEN OF WHAT COUNTRY?
USA | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
Baltimore City MD. | |
| 10. CITY OR TOWN OF DEATH
Baltimore | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
John L. Deaton Medical Center | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
Factory Worker | | 12b. KIND OF BUSINESS OR INDUSTRY | |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)
13a. STATE
Maryland | | 13b. COUNTY
Baltimore | | 13c. CITY OR TOWN
Baltimore | | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
Joseph Wasserman | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
Elizabeth Worm | | 13e. STREET ADDRESS
675 E. Clement St. Balto. Md. | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
No | | 16b. SOCIAL SECURITY NO.
(IF YES, GIVE WAR OR DATES)
212-34-7190 | | 17. INFORMANT
ADDRESS
Mrs. Anna Sisson, 619 E. Clement St. Balto. Md. | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART 1. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Probable Sepsis
4360
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b) Decubitus Ulcers
(c) EVA | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
1 month
3 months
6 months | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:
Parkinson's Disease senile Dementia Congestive Heart Failure | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | |
| 21d. INJURY OCCURRED
WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY
(AT HOME STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 1-19 1982 to 2-24 1982 , that (I) (we) last saw the deceased alive on 2-18-1982 , and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) did (did not) view the body after death. | | | | | | | |
| 22b. SIGNATURE
Alfred J. Daniels MD | | | | DEGREE
ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | 22c. DATE SIGNED
2/24/82 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
Alfred J. Daniels MD | | | | 22e. ADDRESS
510 E. Fort Ave. Baltimore, Md. 21230 | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)
Burial | | 23b. DATE
Feb. 27, 1982 | | 23c. NAME OF CEMETERY OR CREMATORY
Western Cemetery | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
Baltimore, Maryland | |
| 24. FUNERAL DIRECTOR
NAME ADDRESS
McCutty Funeral Home, 130 E. Fort Ave. Balto. Md. | | | | 25a. DATE REC'D. BY REGISTRAR
MAR 2 1982 | | | |
| | | | | 25b. REGISTRAR'S SIGNATURE
James VanNathan | | | |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 2 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury or other traumatic event, the medical examiner will be notified to examine the body.

FOR
1. STATE
REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

8 2 0 3 5 2 4

| | | | | | |
|---|--|---|---|---|-----------------------------------|
| 1. DECEASED NAME
(TYPE OR PRINT)
FIRST <u>Clark</u> MIDDLE <u>May</u> LAST <u>Clark</u> | | | 7a. DATE OF DEATH
MONTH <u>2</u> DAY <u>12</u> YEAR <u>82</u> | | 7b. HOUR <u>11:55</u>
(M) |
| 1. SEX
<u>FEMALE</u> | 4. RACE
<u>C.</u> | 5. DATE OF BIRTH
MONTH <u>11</u> DAY <u>27</u> YEAR <u>1892</u> | 6. AGE (IN YEARS LAST BIRTHDAY)
<u>89</u> YRS | IF UNDER 1 YEAR
MONTHS <u></u> DAYS <u></u> | |
| 7a. BIRTHPLACE
(STATE OR FOREIGN)
<u>MARYLAND</u> | 7b. CITIZEN OF WHAT COUNTRY?
<u>U.S.</u> | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 9. BALTIMORE CITY OR COUNTY OF DEATH
<u>Balti. City</u> MD. | | |
| 10. CITY OR TOWN OF DEATH
<u>Balti. City</u> | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
<u>Lafayette Sq. Reg. Ct.</u> | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE) | | 12b. KIND OF BUSINESS OR INDUSTRY |
| 13a. STATE
<u>MD</u> | 13b. COUNTY
<u></u> | 13c. CITY OR TOWN
<u>Balti. City</u> | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | 13e. STREET ADDRESS
<u>140 W. Lombard St</u> | |
| 14. FATHER'S NAME
FIRST <u>Unknown</u> MIDDLE <u></u> LAST <u></u> | | 15. MOTHER'S MAIDEN NAME
FIRST <u>Unknown</u> MIDDLE <u></u> LAST <u></u> | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN) | | 16b. SOCIAL SECURITY NO. | | 17. INFORMANT ADDRESS | |

| | | |
|--|--|--|
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), or (c).
PART 1: DEATH WAS CAUSED BY
<u>5694</u> IMMEDIATE CAUSE (a) <u>Rectal mass, probable carcinoma</u> | | APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATH
<u>2-3 months</u> |
| DUE TO, OR AS A CONSEQUENCE OF:
(b) <u>Anaemia</u> | | <u>3 months</u> |
| DUE TO, OR AS A CONSEQUENCE OF:
(c) <u>Cachexia</u> | | |

PART 2: OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: Hematuria

| | | | |
|--|--|--|--|
| 19a. DATE OF OPERATION | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | 20b. IF YES, WERE FINDINGS USED
IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. <u>19</u> | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/> | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>12/22/81</u> to <u>2/12/82</u> , that (I) (we) lost
saw the deceased alive on <u>2/12/82</u> 19 <u>82</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated
above, (I) (we) did (did not) view the body after death. | | | |
| 22b. SIGNATURE
<u>Amatun N. Naeem</u> | | DEGREE
<u>MD</u> | 22c. DATE SIGNED |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
<u>AMATUN N. NAEEM</u> | | 22e. ADDRESS
<u>501. Dolphin street Balto MD</u> | |

| | | | |
|---|-----------------------------|---|---|
| 23a. BURIAL, CREMATION, REMOVAL
(TYPE) | 23b. DATE
<u>2/19/82</u> | 23c. NAME OF CEMETERY OR CREMATORY
<u>St. Charles Cemetery</u> | 23d. LOCATION
(CITY OR TOWN COUNTY STATE)
<u>Balti. City MD</u> |
| 24. FUNERAL DIRECTOR
(TYPE OR PRINT)
<u>Joe Carroll</u> | | 25a. DATE REC'D. BY REGISTRAR
<u>FEB 17 1982</u> | 25b. REGISTRAR'S SIGNATURE
<u>James J. Nathan</u> |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be called.

1- FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

8 2 0 3 6 2 5

| | | | | | |
|---|---|---|--|--|---|
| 1. DECEASED NAME
(TYPE OR PRINT)
FIRST MIDDLE LAST
FLOYD R. CLARKE | | | 2a. DATE OF DEATH
MONTH DAY YEAR
Feb 3 82 | | 2b. HOUR
1:50 AM |
| 3. SEX
Male | 4. RACE
White | 5. DATE OF BIRTH
MONTH DAY YEAR
Oct 3, 1921 | 6. AGE (IN YEARS LAST BIRTHDAY)
60 yrs | | IF UNDER 1 YEAR
MONTHS DAYS
IF UNDER 24 HRS
HOURS MIN. |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
Maryland | 7b. CITIZEN OF WHAT COUNTRY?
U.S.A | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 9. BALTIMORE CITY OR COUNTY OF DEATH
BALTIMORE CITY MD. | | |
| 10. CITY OR TOWN OF DEATH
CITY | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
UNION MEMORIAL HOSPITAL | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
Painter | 12b. KIND OF BUSINESS OR INDUSTRY
- | |
| 13a. STATE
Maryland | | | 13b. COUNTY
- - | 13c. CITY OR TOWN
Baltimore | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
Charles H. Clarke | | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
Florence Cavey | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
Yes | | 16b. SOCIAL SECURITY NO.
(IF YES, GIVE WAR OR DATES)
WW II 215-12-0052 | 17. INFORMANT
ADDRESS
Mrs Gladys Clarke-844 West 37th St. 21211 | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART 1. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) CARDIO PULMONARY ARREST
5739
DUE TO, OR AS A CONSEQUENCE OF
(b) Given FAILURE on chirosci
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last
DUE TO, OR AS A CONSEQUENCE OF
(c) | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
1 Immed. AM |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:
2 | | | | | |
| 19a. DATE OF OPERATION
2 | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK AT WORK | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | |
| 22a. I certify that (I) (this hospital) attended the deceased from 1/31/82 19 82 , to 2/3/82 19 82 , that (I) (we) last saw the deceased alive on 2/3/82 19 82 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (If I/we did not view the body after death.) | | | | | |
| 22b. SIGNATURE
John C. Umman M.D. | | | | DEGREE
MD | 22c. DATE SIGNED
12/3/82 |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
JOHN C. UMMAN | | | | 22e. ADDRESS
201 UNIVERSITY PARKWAY | |
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)
Burial | | 23b. DATE
2/5/82 | 23c. NAME OF CEMETERY OR CREMATORY
Crest Lawn Gdns. | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
Marroittsville, Maryland |
| 24. FUNERAL DIRECTOR
NAME
A. Alan Seitz Funeral Home | | | | 25a. DATE REC'D. BY REGISTRAR
FEB 5 1982 | |
| ADDRESS
3818 Roland Ave. | | | | 25b. REGISTRAR'S SIGNATURE
Thomas J. [Signature] | |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be filed within 72 hours after death. Page 3 may be filed at any time.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

DHMH - 16 50M 1/81
(VRA 15, 4)

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 2 0 3 5 2 6

REG. NO.

1- FOR
STATE
REGISTRAR

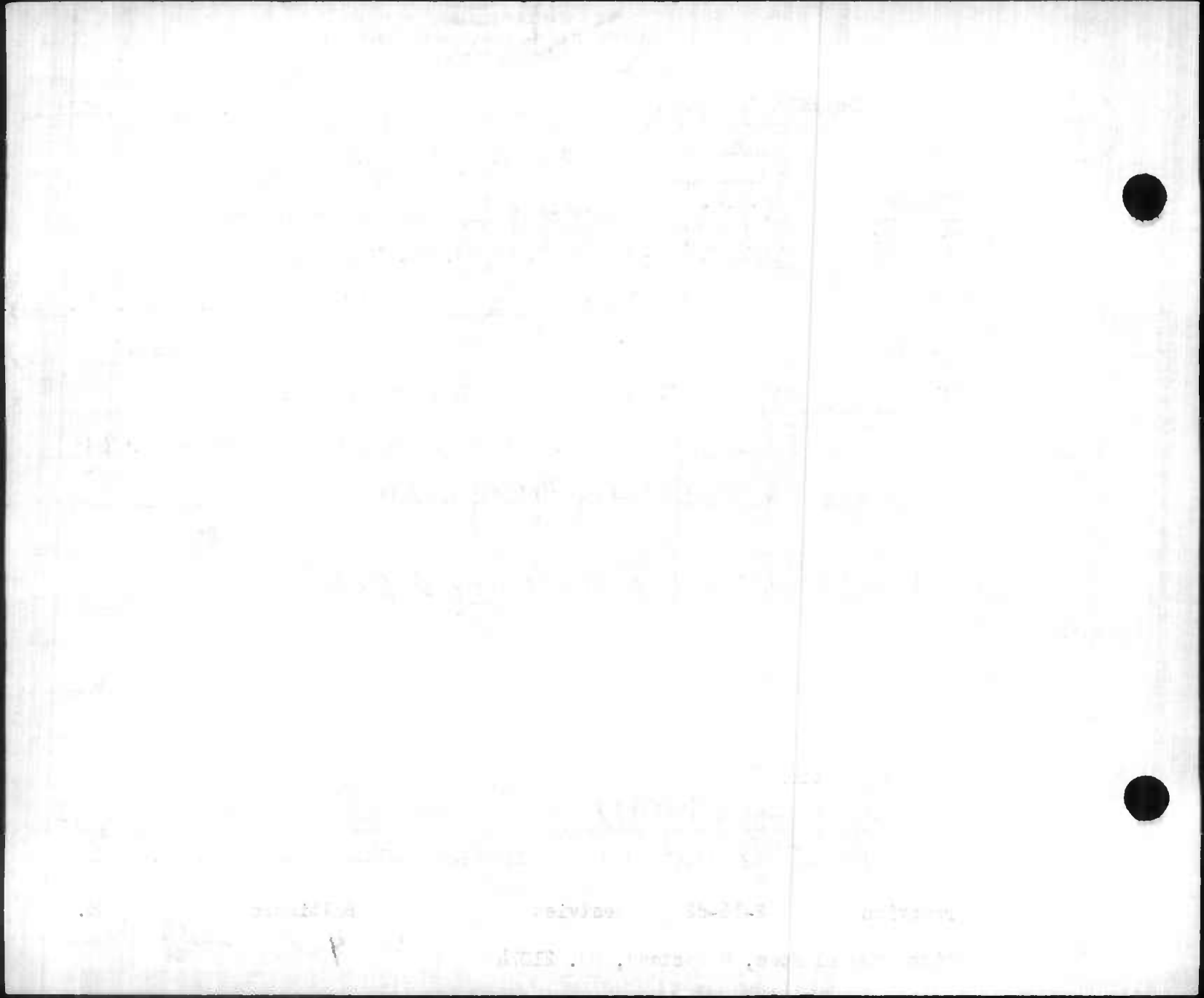
| | | | | | |
|---|--|---|--|--|--|
| 1. DECEASED NAME
(TYPE OR PRINT)
THEODORE DARWIN CLARY | | | 2a. DATE OF DEATH
MONTH DAY YEAR
FEB. 11 82 | | 2b. HOUR
7:15A M |
| 3. SEX
MALE | 4. RACE
WHITE | 5. DATE OF BIRTH
MONTH DAY YEAR
5 18 06 | 6. AGE (IN YEARS LAST BIRTHDAY)
75 | IF UNDER 1 YEAR
MONTHS DAYS
IF UNDER 24 HRS
HOURS MIN. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN)
MARYLAND | 7b. CITIZEN OF WHAT COUNTRY?
U.S.A. | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 9. BALTIMORE CITY OR COUNTY OF DEATH
BALTIMORE CITY MD | | |
| 10. CITY OR TOWN OF DEATH
BALTIMORE | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
VAMC, LOCH RAVEN BLVD. BALTO. MD. | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
FLOOR FINISHER | 12b. KIND OF BUSINESS OR INDUSTRY | |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)
13a. STATE
MARYLAND | | | 13b. COUNTY | 13c. CITY OR TOWN
BALTIMORE | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
JOHN CLARY | | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
IDA STORM | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
YES WWII | | 16b. SOCIAL SECURITY NO.
(IF YES, GIVE WAR OR DATES)
217 01 6445 | 17. INFORMANT
ADDRESS
VAMC, LOCH RAVEN BLVD. RECORDS | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART 1. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Myocardial Infarction / Congestive Heart Failure days
4100 } DUE TO, OR AS A CONSEQUENCE OF (b) Coronary Artery Disease years
Conditions, if any, which gave rise to immediate cause (c), stating the underlying cause last } DUE TO, OR AS A CONSEQUENCE OF (c) | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a):
Chronic Obstructive Pulmonary Disease | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input type="checkbox"/> | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1B, PART 1 OR PART 2) | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK AT WORK | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | |
| 22a. I certify that (x) (this hospital) attended the deceased from FEBRUARY 5 1982 to FEBRUARY 11 1982, that (x) (we) lost saw the deceased alive on FEBRUARY 11 1982, and that in (x) (our) opinion death occurred on the date and hour and from the causes stated above. (If not, (did) (did not) view the body after death.) | | | | | |
| 22b. SIGNATURE
Arthur J. Lomant MD | | DEGREE
ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> | | 22c. DATE SIGNED
2/11/82 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
Arthur J. Lomant MD. | | 22e. ADDRESS
3900 LOCH RAVEN BLVD. BALTO. MD. 21218 | | | |
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)
Cremation | | 23b. DATE
2-16-82 | 23c. NAME OF CEMETERY OR CREMATORY
Westview | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
Baltimore Md. |
| 24. FUNERAL DIRECTOR
NAME
Eline Funeral Home, Hampstead, Md. 21074 | | 25a. DATE REG'D BY REGISTRAR
FEB 24 1982 | | 25b. REGISTRAR'S SIGNATURE
[Signature] | |

MEDICAL CERTIFICATION

9
9

1

0104 BP



TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

Item 18b G566 4/22/82 dad

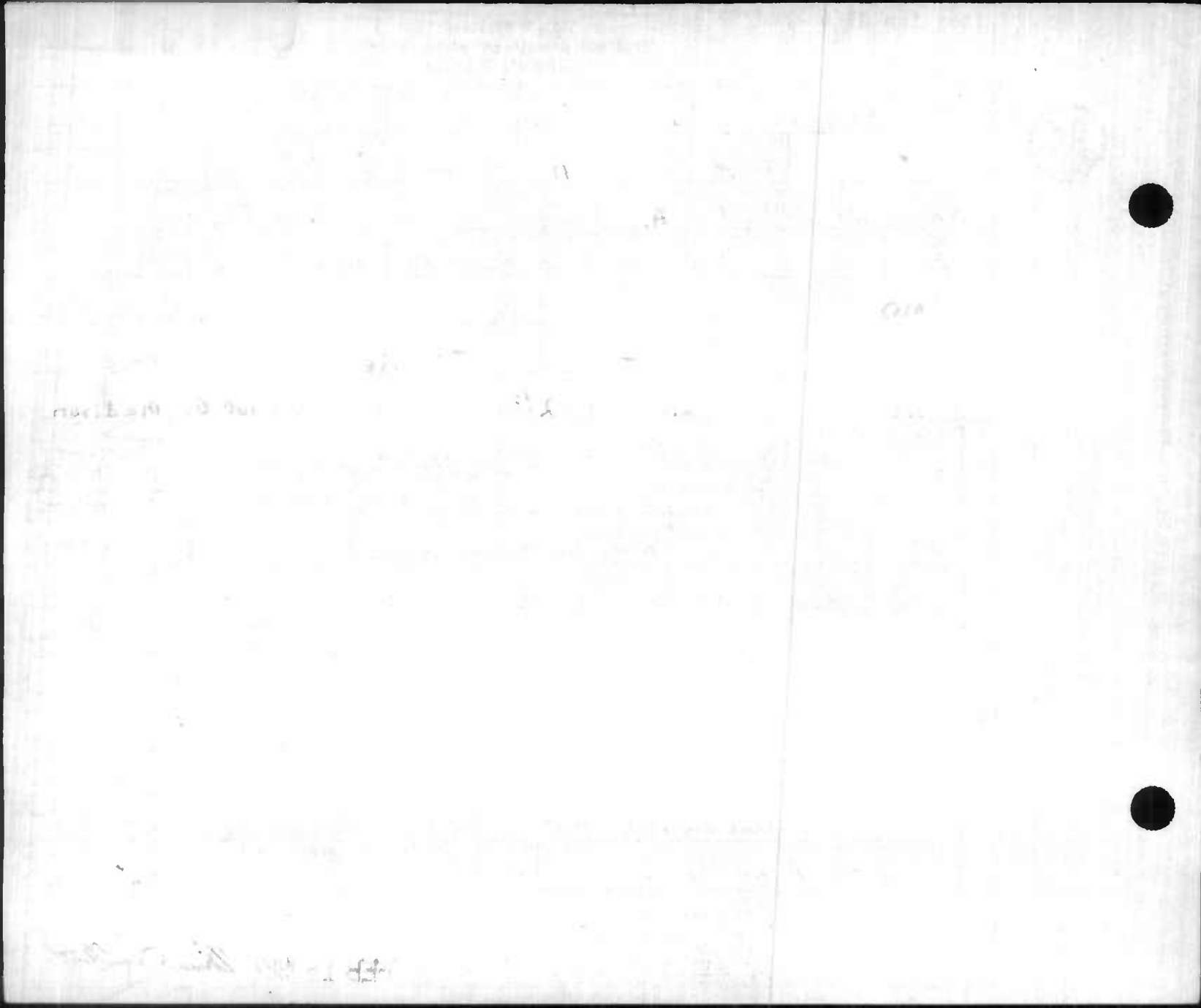
FOR
1- STATE
REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 2 0 3 0 2 1

REG. NO.

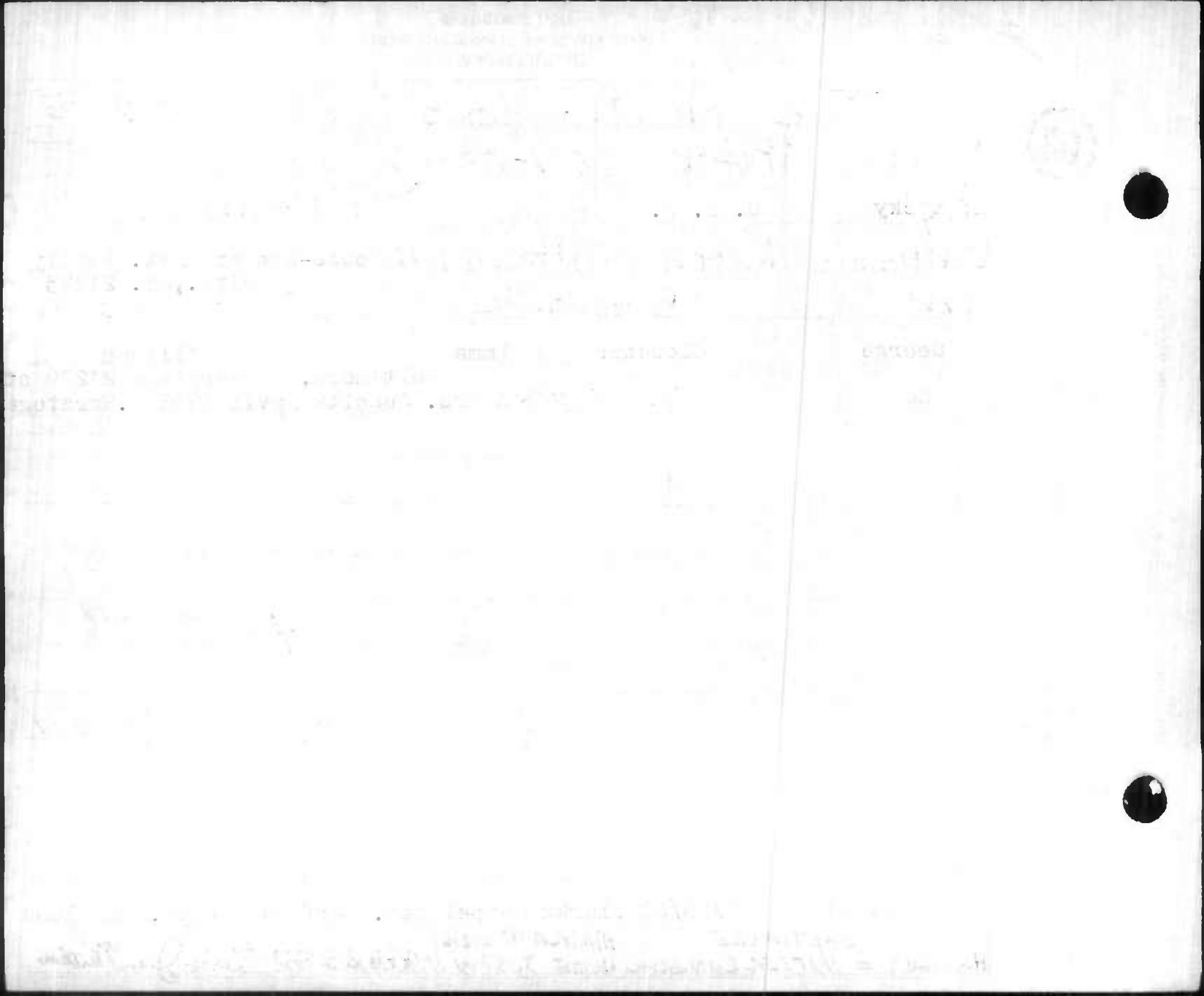
| | | | | | | |
|--|--------------------|---|---|---|---------------------------|--|
| 1 DECEASED NAME
(TYPE OR PRINT) FIRST MIDDLE LAST
BERTHA C. CLAY | | | 2a DATE OF DEATH MONTH DAY YEAR
2 14 82 | | 2b HOUR
3:23 AM | |
| 3 SEX
F | 4 RACE
B | 5 DATE OF BIRTH MONTH DAY YEAR
11 08 96 | | 6 AGE (IN YEARS LAST BIRTHDAY) YRS. MONTHS DAYS
85 | | |
| 7a BIRTHPLACE (STATE OR FOREIGN COUNTRY)
BALTO. Md. | | 7b CITIZEN OF WHAT COUNTRY?
U.S. A. | | 9 BALTIMORE CITY OR COUNTY OF DEATH
BALTO. City MD. | | |
| 10 CITY OR TOWN OF DEATH
BALTO. | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
Mercy Hospital, BALTO. Md. | | 12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)
Home MAKER | | |
| 13a STATE
MO | | 13b COUNTY
BALTO. | | 13c CITY OR TOWN
BALTO. | | |
| 14 FATHER'S NAME FIRST MIDDLE LAST
- - - | | 15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST
Jennie CHASE | | 16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)
NO | | |
| 16b SOCIAL SECURITY NO.
217-26-3042 | | 17 INFORMANT ADDRESS
Henrietta Brown 1400 E. Madison | | | | |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY:
5849 IMMEDIATE CAUSE (a) CARDIAC Arrhythmia
DUE TO, OR AS A CONSEQUENCE OF Prescribed for atrial fibrillation with
(b) Dig. ADIS Toxicity rapid response 13 seconds
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. } DUE TO, OR AS A CONSEQUENCE OF 72 days
(c) Acute Myocardial Failure 72 days | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:
Anemia, Dehydration, Possible Colon Ca., Paget's Disease | | | | | | |
| 19a DATE OF OPERATION | | 19b CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | |
| 21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2) | | |
| 21d INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK | | 21e PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f LOCATION STREET CITY OR TOWN COUNTY STATE | | |
| 22a I certify that (I) (this hospital) attended the deceased from 11/13 , 19 82 , to 11/14 , 19 82 , that (I) (we) lost sight of the deceased on 11/13 , 19 82 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above (I) (we) (did) (did not) view the body after death. | | | | | | |
| 22b SIGNATURE
Scott Allan Spier | | DEGREE
M.D. | | 22c DATE SIGNED
2/14/82 | | |
| 22d PHYSICIAN'S NAME (TYPE OR PRINT)
SCOTT ALLAN SPIER | | 22e ADDRESS
MERCY HOSPITAL;
301 St. Paul Place; BALTO 21202 | | | | |
| 23a BURIAL, CREMATION, REMOVAL (SPECIFY)
Burial | | 23b DATE
2/19/82 | | 23c NAME OF CEMETERY OR CREMATORY
Mt. Auburn Cem. | | |
| 23d LOCATION CITY OR TOWN COUNTY STATE
Baltimore MD | | 24 FUNERAL DIRECTOR NAME ADDRESS
Wm. C. March F/H 1101 E. North Ave. | | | | |
| 25a DATE REC'D. BY REGISTRAR | | 25b REGISTRAR'S SIGNATURE
FEB 16 1982 [Signature] | | | | |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use on the burial transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. (IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.)

| STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH | | | | 8 2 0 3 6 2 8 | | | |
|---|--|---|--|--|--|---|--|
| 1- FOR STATE REGISTRAR | | | | REG. NO. | | | |
| 1. DECEASED NAME (TYPE OR PRINT) TEE N Clouders | | | | 2a. DATE OF DEATH MONTH DAY YEAR 02-21-82 | | 2b. HOUR 5:33 M | |
| 3. SEX Female | | 4. RACE Black | | 5. DATE OF BIRTH MONTH DAY YEAR 07-03-88 | | 6. AGE (IN YEARS 1/4, 1/2 BIRTHDAY) 93 YRS. | |
| 7a. PLACE OF BIRTH (STATE OR FOREIGN COUNTRY) Kentucky | | 7b. CITIZEN OF WHAT COUNTRY? U. S. A. | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore MD. | |
| 10. CITY OR TOWN OF DEATH Baltimore | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Lutheran Hospital | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) House-keeper | | 12b. KIND OF BUSINESS OR INDUSTRY Pvt. Family | |
| 13a. STATE Md. | | 13b. COUNTY Baltimore | | 13c. CITY OR TOWN Baltimore | | 13d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO | |
| 14. FATHER'S NAME FIRST MIDDLE LAST George Clouders | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Emma Williams | | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No | | | |
| 16b. SOCIAL SECURITY NO. 218541302 | | 17. INFORMANT Baltimore, Maryland 21229 st A Mrs. Juanita Davis 3703 W. Saratoga | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardio Pulmonary arrest
5789
DUE TO, OR AS A CONSEQUENCE OF (b) Gastrointestinal bleeding
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO, OR AS A CONSEQUENCE OF (c)
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR 2:30 P.M. 1982 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1, OR PART 2) | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) Lutheran Hospital | | 21f. LOCATION (CITY OR TOWN) Baltimore COUNTY Md. | | | |
| 22. I certify that (I) (this hospital) attended the deceased from 2/21/82 19 82 to 2/21/82 19 82 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | |
| 22a. SIGNATURE Henny J. Sacerin | | | | DEGREE PHYSICIAN | | 22b. DATE SIGNED | |
| 22c. PHYSICIAN'S NAME (TYPE OR PRINT) Henny J. Sacerin | | | | 22d. ADDRESS X | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | | 23b. DATE 2/25/82 | | 23c. NAME OF CEMETERY OR CREMATORY Clarks Chapel Cem. | | 23d. LOCATION (CITY OR TOWN) Harford County, Maryland | |
| 24. FUNERAL DIRECTOR NAME BALTIMORE HERBERT E. NUTTER FUNERAL HOME | | | | 25a. DATE REC'D. BY REGISTRAR FEB 23 1982 | | 25b. REGISTRAR'S SIGNATURE James Van Natta | |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified in person.FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

8 2 0 3 6 2 9

| | | | | | |
|--|---|---|--|--|--|
| 1. DECEASED NAME
(TYPE OR PRINT)
Frank J. Coach | | | 2a. DATE OF DEATH
MONTH DAY YEAR
February 26, 1982 | | 2b. HOUR
9:45P M |
| 3. SEX
Male | 4. RACE
White | 5. DATE OF BIRTH
MONTH DAY YEAR
Oct. 9, 1905 | | 6. AGE (IN YEARS (LAST BIRTHDAY))
76 YRS. | IF UNDER 1 YEAR
MONTHS DAYS
IF UNDER 24 HRS.
HOURS MIN. |
| 7a. BIRTHPLACE
(STATE OR FOREIGN COUNTRY)
Maryland | 7b. CITIZEN OF WHAT COUNTRY?
U.S.A. | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
Baltimore City MD. | |
| 10. CITY OR TOWN OF DEATH
Baltimore | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
Maryland General Hospital | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
Food Service Attendant Hospital | | |
| 13a. STATE
Maryland | 13b. COUNTY | 13c. CITY OR TOWN
Baltimore | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | 13e. STREET ADDRESS
301 McMechen St. | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
Unknown | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
Unknown | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
No | 16b. SOCIAL SECURITY NO.
(IF YES, GIVE WAR OR DATES)
120-20-0414 | 17. INFORMANT
ADDRESS
Charles Hoofnagle 3708 Delverne Rd. | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART 1. DEATH WAS CAUSED BY:
4100 Acute Cardiopulmonary Arrest
IMMEDIATE CAUSE (a)
DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b) Atherosclerotic Coronary Vascular
DUE TO, OR AS A CONSEQUENCE OF
(c) | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TESTED CAUSE OF DEATH. GIVE IN PART 1.
History of MI, Ventricular arrhythmia in past; Pacemaker Insertion; Congestive Heart Failure; | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input type="checkbox"/> | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | |
| 22a. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from February 23, 1982 to February 26, 1982 , that <input checked="" type="checkbox"/> (we) lost saw the deceased alive on February 26, 1982 , and that in <input checked="" type="checkbox"/> (my) (our) opinion death occurred on the date and hour and from the causes stated above. (If (we) (did) (did not) view the body after death. | | | | | |
| 22b. SIGNATURE
<i>Judith Veihmeyer</i> | | DEGREE
MD | | 22c. DATE SIGNED
2/27/82 | |
| 22e. PHYSICIAN'S NAME (TYPE OR PRINT)
Judith Veihmeyer MD | | 22e. ADDRESS
c/o Maryland General Hospital | | | |
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)
Burial | | 23b. DATE
March 2, 1982 | 23c. NAME OF CEMETERY OR CREMATORY
Moreland Mem. Park | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
Baltimore Maryland |
| 24. FUNERAL DIRECTOR
NAME ADDRESS
Leonard J. Ruck, Inc. Baltimore, Maryland | | | 25a. DATE REC'D. BY REGISTRAR
MAR 1 1982 | | |

Large family album, 1912.

Antique, 1912, 1913, 1914.

Constitution, 1912, 1913.

Constitution, 1912, 1913, 1914.

History of

State, 1912, 1913.

State, 1912, 1913, 1914.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. It may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

FOR
1 - STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | | | | | |
|---|--|---|--------|---|-------------------|--------------------------------------|-------|-----------------|------|------------------|--|
| 1. DECEASED NAME
(TYPE OR PRINT) | | FIRST | MIDDLE | LAST | 2a. DATE OF DEATH | | MONTH | DAY | YEAR | 2b. HOUR | |
| John | | | | Colbert Sr. | February 28, 1982 | | | | | 12:05 a | |
| 3. SEX | | 4. RACE | | 5. DATE OF BIRTH | | 6. AGE (IN YEARS LAST BIRTHDAY) | | IF UNDER 1 YEAR | | IF UNDER 24 HRS. | |
| Male | | Black | | 8 MONTH 26 00 | | 81 | | MONTHS DAYS | | HOURS MIN. | |
| 7a. BIRTHPLACE
(STATE OR FOREIGN COUNTRY) | | 7b. CITIZEN OF WHAT COUNTRY? | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH | | | | | |
| Ala. | | USA | | | | Baltimore City MD | | | | | |
| 10. CITY OR TOWN OF DEATH | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) | | | | | | | | | |
| Baltimore | | Maryland General Hosp. | | | | | | | | | |
| 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE) | | | | | | | | | | | |
| 12b. KIND OF BUSINESS OR INDUSTRY | | | | | | | | | | | |
| 13a. STATE | | | | | | | | | | | |
| MD | | | | | | | | | | | |
| 13b. COUNTY | | | | | | | | | | | |
| Baltimore | | | | | | | | | | | |
| 13c. CITY OR TOWN | | | | | | | | | | | |
| Baltimore | | | | | | | | | | | |
| 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | | | | | | | | | |
| 13e. STREET ADDRESS | | | | | | | | | | | |
| 1027 Cathedral St. | | | | | | | | | | | |
| 14. FATHER'S NAME | | | | | | | | | | | |
| Elijah | | | | | | | | | | | |
| 15. MOTHER'S MAIDEN NAME | | | | | | | | | | | |
| Lora | | | | | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN) | | | | | | | | | | | |
| No | | | | | | | | | | | |
| 16b. SOCIAL SECURITY NO. | | | | | | | | | | | |
| 212-09-6727 | | | | | | | | | | | |
| 17. INFORMANT | | | | | | | | | | | |
| Laylor Colbert | | | | | | | | | | | |
| ADDRESS | | | | | | | | | | | |
| 1027 Cathedral St. | | | | | | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) | | | | | | | | | | | |
| PART 1. DEATH WAS CAUSED BY: | | | | | | | | | | | |
| IMMEDIATE CAUSE (a) Sepsis | | | | | | | | | | | |
| 7071 | | | | | | | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF | | | | | | | | | | | |
| (b) Cellulitis right leg | | | | | | | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF | | | | | | | | | | | |
| (c) Ulcer right leg | | | | | | | | | | | |
| several months | | | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) | | | | | | | | | | | |
| CVA, Poor nutrition | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | | | | | | | | | |
| February 24, 82 | | | | | | | | | | | |
| 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | | | | | | | | |
| Ulcer right leg Debridement | | | | | | | | | | | |
| 20a. AUTOPSY? | | | | | | | | | | | |
| YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | | | | | | | |
| 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? | | | | | | | | | | | |
| YES <input type="checkbox"/> NO <input type="checkbox"/> | | | | | | | | | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER NOTIFY MEDICAL EXAMINER) | | | | | | | | | | | |
| 21b. TIME OF INJURY | | | | | | | | | | | |
| HOUR A.M. MONTH DAY YEAR | | | | | | | | | | | |
| P.M. 19 | | | | | | | | | | | |
| 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1, OR PART 2) | | | | | | | | | | | |
| 21d. INJURY OCCURRED | | | | | | | | | | | |
| 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | | | | | | | | | | |
| 21f. LOCATION | | | | | | | | | | | |
| STREET CITY OR TOWN COUNTY STATE | | | | | | | | | | | |
| 22a. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from December 22, 19 81, to February 28, 19 82, that <input checked="" type="checkbox"/> (we) lost
saw the deceased alive on February 28, 19 82, and that <input checked="" type="checkbox"/> (our) opinion death occurred on the date and hour and from the causes stated
above. <input checked="" type="checkbox"/> (we) did not view the body after death. | | | | | | | | | | | |
| 22b. SIGNATURE | | | | | | | | | | | |
| J. Rutkowski, MD | | | | | | | | | | | |
| 22c. DATE SIGNED | | | | | | | | | | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) | | | | | | | | | | | |
| Janice Rutkowski MD | | | | | | | | | | | |
| 22e. ADDRESS | | | | | | | | | | | |
| c/o Maryland General Hospital | | | | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY) | | | | | | | | | | | |
| Burial | | | | | | | | | | | |
| 23b. DATE | | | | | | | | | | | |
| 3/4/82 | | | | | | | | | | | |
| 23c. NAME OF CEMETERY OR CREMATORY | | | | | | | | | | | |
| King Memorial Pk. | | | | | | | | | | | |
| 23d. LOCATION | | | | | | | | | | | |
| Baltimore Co. MD | | | | | | | | | | | |
| 24. FUNERAL DIRECTOR | | | | | | | | | | | |
| NAME ADDRESS | | | | | | | | | | | |
| Wm. C. March F/H 1101 E. North Ave. | | | | | | | | | | | |
| 25a. DATE REC'D. BY REGISTRAR | | | | | | | | | | | |
| MAR 1 1982 | | | | | | | | | | | |
| 25b. REGISTRAR'S SIGNATURE | | | | | | | | | | | |
| Janice J. Rutkowski | | | | | | | | | | | |

100-100000

January 10, 1950

Colony

1000

1000-100000

1000-100000

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1000-100000

1000-100000

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE VITAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 IN YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITH VITAL RECORDS, DIVISION OF VITAL RECORDS, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP

DHMH-17
(VR A15 ME (3))
15M 2/80

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

FOR
1- STATE
REGISTRAR

| | | | | | | | | |
|---|------------------|---|---|---|---|--|---|-----------------------------------|
| 1. DECEASED NAME
(TYPE OR PRINT) (GARY) GARRY L. COLEMAN | | | 2a. DATE KNOWN OF DEATH
ESTIMATED <input checked="" type="checkbox"/> MONTH DAY YEAR 2 27 1982 | | | 2b. HOUR 4:30 M | | |
| 3. SEX
male | 4. RACE
NEGRO | 5. DATE OF BIRTH
MONTH DAY YEAR JULY 23 1962 | 6. AGE (IN YEARS)
LAST BIRTHDAY 19 YRS. | IF UNDER 1 YR.
MONTHS DAYS | IF UNDER 24 HRS.
HOURS MIN | 2c. DATE PRONOUNCED DEAD
MONTH DAY YEAR 2 27 1982 | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
MARYLAND | | 7b. CITIZEN OF WHAT COUNTRY?
U.S.A. | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
Baltimore City MD | | |
| 10. CITY OR TOWN OF DEATH
Baltimore | | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION
(IF NOT IN BUREAU CITY, GIVE STREET ADDRESS)
Front/156 S. Calverton Road | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)
MEDICAL STUDENT | | 12b. KIND OF BUSINESS OR INDUSTRY |
| USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)
13a. STATE MARYLAND | | | 13b. COUNTY | | 13c. CITY OR TOWN
BALTIMORE | | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST CLARENCE COLEMAN | | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST AMELIA VAUGHN | | | 13e. STREET ADDRESS
2542 W. FAYETTE ST 21223 | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO, OR UNKNOWN) NO | | | 16b. SOCIAL SECURITY NO.
212-82-0076 | | 17. INFORMANT ADDRESS
AMELIA COLEMAN/2542 W. FAYETTE ST. | | | |

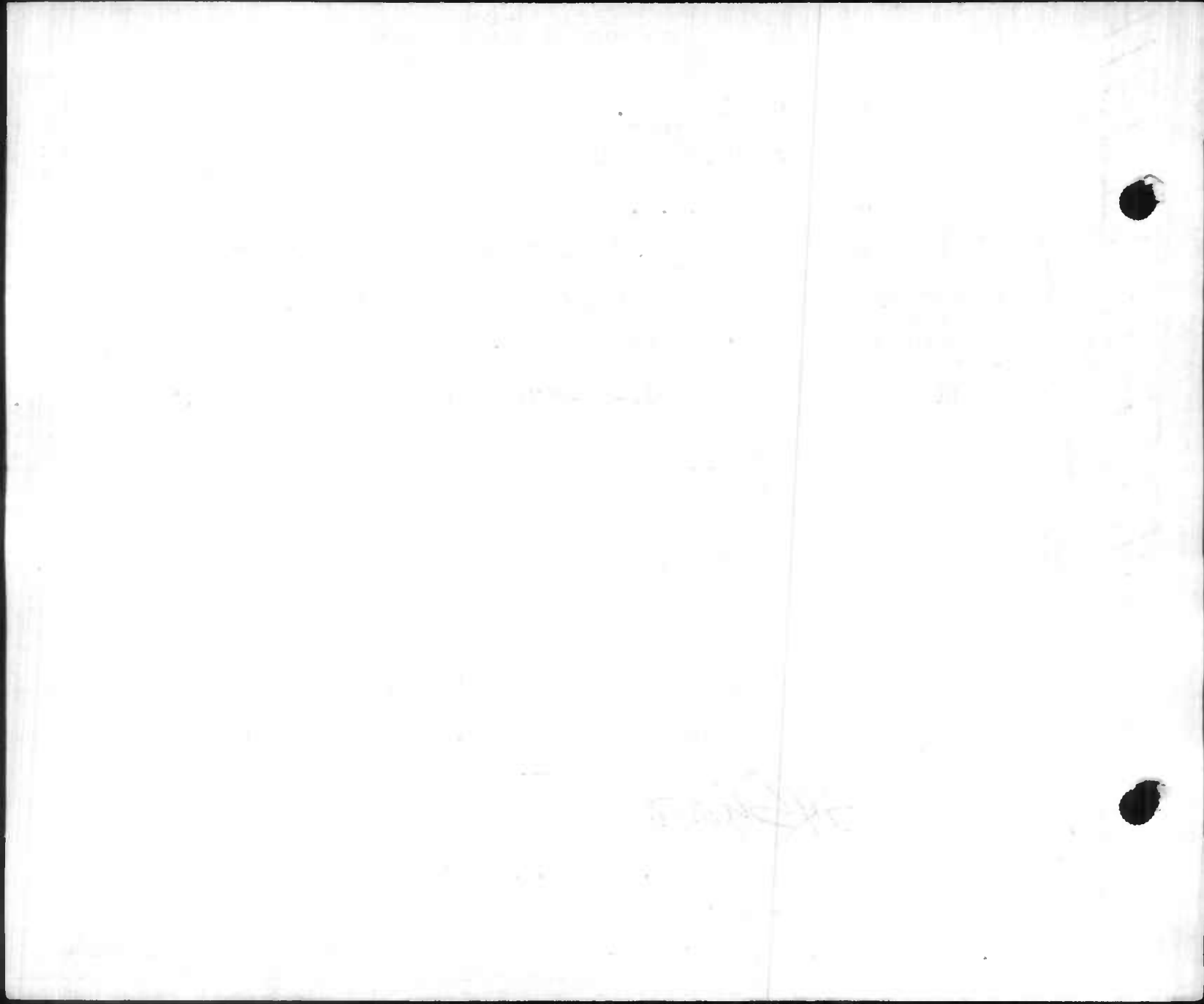
MEDICAL CERTIFICATION

| | | |
|--|--|--|
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>Gunshot wound of chest</u> WEAPON: <u>handgun</u>
DUE TO, OR AS A CONSEQUENCE OF
(b) _____
DUE TO, OR AS A CONSEQUENCE OF
(c) _____ | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
|--|--|--|

PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a).

| | | | | | |
|--|--|---|--|---|--|
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | | 20. AUTOPSY?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. EXTERNAL CAUSE WAS
UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR 4:05 AM 2/27 19 82 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)
subject shot | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK <input type="checkbox"/> AT WORK <input checked="" type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)
sidewalk | | 21f. LOCATION
CITY OR TOWN STREET COUNTY STATE
front/156 S. Calverton Rd, Baltimore, MD | |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input checked="" type="checkbox"/> Undetermined manner <input type="checkbox"/> . | | | | | |
| ACTUAL SIGNATURE
<i>H. Guard</i> | | TITLE (SPECIFY)
Assistant | | DATE SIGNED
2/27/82 | |
| EXAMINER'S NAME
(TYPE OR PRINT) | | Hormez R. Guard, M.D. ADDRESS 111 Penn Street, Balto., MD 21201 | | | |

| | | | |
|---|-----------------------|---|--|
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY) BURIAL | 23b. DATE
03/03/82 | 23c. NAME OF CEMETERY OR CREMATORY
BALTIMORE CEMETERY | 23d. LOCATION
CITY OR TOWN COUNTY STATE
BALTIMORE MARYLAND |
| 24. FUNERAL DIRECTOR
MARSHALL W JONES, JR/4101 EDMONDSON AVE | | 25a. DATE REC'D. BY REGISTRAR 25b. REGISTRAR'S SIGNATURE
MAR 2 1982 <i>James J. Nathan</i> | |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. **Page 1** may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 2 0 3 6 3 2

| 1. DECEASED NAME (TYPE OR PRINT) | | | 2a. DATE OF DEATH | | | 2b. HOUR | | |
|--|--|------------------------------------|--|---|------|--|------------------------|--|
| FIRST | MIDDLE | LAST | MONTH | DAY | YEAR | MONTH | DAY | YEAR |
| James | E. | Coleman | 2 | 22 | 82 | 8:30 | AM | |
| 3. SEX | 4. RACE | 5. DATE OF BIRTH | 6. AGE (IN YEARS LAST BIRTHDAY) | | | 7. IF UNDER 1 YEAR | | |
| M | B | 8 8 25 | 56 | YRS. | | | MONTHS DAYS HOURS MIN. | |
| 8. BIRTHPLACE (STATE OR FOREIGN COUNTRY) | 9. BALTIMORE CITY OR COUNTY OF DEATH | 10. CITY OR TOWN OF DEATH | | | | | | |
| BALTO. Md. | Baltimore City | Baltimore City MD | | | | | | |
| 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION | 12a. USUAL OCCUPATION | | | 12b. KIND OF BUSINESS OR INDUSTRY | | | | |
| Pleasant Manor Nursing Center | Chauffeur | | | RETAIL | | | | |
| 13a. STATE | 13b. COUNTY | 13c. CITY OR TOWN | 13d. INSIDE CITY LIMITS? | 13e. STREET ADDRESS | | | | |
| Md. | | Baltimore | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | 5229 Reisterstown Rd. | | | | |
| 14. FATHER'S NAME | 15. MOTHER'S MAIDEN NAME | | | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? | | | | |
| WALTER | Evelyn | | | Yes (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) | | | | |
| 16b. SOCIAL SECURITY NO. | 17. INFORMANT | | | 18. CAUSE OF DEATH | | | | |
| 219-501512 | 250 4615 Pk. Hghts. Ave. 21215 | | | PART 1. DEATH WAS CAUSED BY: | | | | |
| | | | | IMMEDIATE CAUSE (a) | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| | | | | Cardiac arrest | | | | 1 day |
| | | | | DUE TO, OR AS A CONSEQUENCE OF | | | | 3 year |
| | | | | Cerebral Thrombosis | | | | |
| | | | | DUE TO, OR AS A CONSEQUENCE OF | | | | 4 year |
| | | | | Arteriosclerotic C.V. Disease | | | | |
| | | | | Spontaneous | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: | | | | | | | | |
| None | | | | | | | | |
| 19a. DATE OF OPERATION | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY? | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? | | |
| | | | | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | YES <input type="checkbox"/> NO <input type="checkbox"/> | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | 21b. TIME OF INJURY | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | | | |
| | HOUR A.M. MONTH DAY YEAR | | | | | | | |
| | P.M. 19 | | | | | | | |
| 21d. INJURY OCCURRED | 21e. PLACE OF INJURY | | 21f. LOCATION | | | | | |
| WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | STREET CITY OR TOWN COUNTY STATE | | | | | |
| 22a. I certify that (I) (the hospital) attended the deceased from <u>March 20, 1982</u> to <u>Feb 22, 1982</u> , that (I) (we) lost saw the deceased alive on <u>Feb 22, 1982</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | |
| 22b. SIGNATURE | | | DEGREE | | | 22c. DATE SIGNED | | |
| Manuel Levin M.D. | | | M.D. | | | 2/22/82 | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) | | | 22e. ADDRESS | | | | | |
| MANUEL LEVIN M.D. | | | 6101 PK Hghts Ave BALTO MD 21215 | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL | 23b. DATE | 23c. NAME OF CEMETERY OR CREMATORY | | 23d. LOCATION | | | | |
| Burial | 2-26-82 | BALTO NAT | | BALTO COUNTY MD | | | | |
| 24. FUNERAL DIRECTOR | | | 25a. DATE REC'D. BY REGISTRAR | | | 25b. REGISTRAR'S SIGNATURE | | |
| JAS. A. MORTON & SONS | | | 1701 LAURENS | | | FEB 23 1982 | | |

575

252

205

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Physicians be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon copies. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH | | | | | | | | | | | | | |
|--|--|---|--|---|--|--|--|---|--|---|--|--|--|
| 1- FOR STATE REGISTRAR | | REG. NO. | | 8 2 0 3 0 3 3 | | | | | | | | | |
| 1. DECEASED NAME (TYPE OR PRINT) | | | | 2a. DATE OF DEATH | | MONTH | | DAY | | YEAR | | 2b. HOUR | |
| John ROBERT Coleman | | | | 2 | | 17 | | 82 | | | | 232 PM | |
| 3 SEX | | 4 RACE | | 5 DATE OF BIRTH | | 6 AGE (IN YEARS LAST BIRTHDAY) | | IF UNDER 1 YEAR | | IF UNDER 24 HRS | | | |
| Male | | White | | 2 16 12 | | 70 YRS | | MONTHS | | DAYS | | HOURS MIN. | |
| 7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) | | 7b CITIZEN OF WHAT COUNTRY? | | 8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9 BALTIMORE CITY OR COUNTY OF DEATH | | | | | | | |
| Maryland | | U.S.A. | | | | Baltimore City MD | | | | | | | |
| 10 CITY OR TOWN OF DEATH | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION | | 12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | | 12b. KIND OF BUSINESS OR INDUSTRY | | | | | | | |
| Baltimore | | Good Samaritan | | | | John Hopkins Traylor Bldg | | | | | | | |
| 13a STATE | | | | 13b COUNTY | | 13c CITY OR TOWN | | 13d INSIDE CITY LIMITS? | | 13e STREET ADDRESS | | | |
| Maryland | | | | | | Baltimore | | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 1117 E. Belvedere Ave. 21239 | | | |
| 14 FATHER'S NAME | | | | 15 MOTHER'S MAIDEN NAME | | | | | | | | | |
| James H. Coleman | | | | Mary Patzwall | | | | | | | | | |
| 16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) | | | | 16b SOCIAL SECURITY NO. | | 17 INFORMANT ADDRESS | | | | | | | |
| No | | | | 213-01-0458 | | Mrs Loretta C. Hyatt 2918 Hillcrest Ave. | | | | | | | |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: | | | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| IMMEDIATE CAUSE (a) <u>Cardiopulmonary arrest.</u> | | | | | | | | | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF (b) <u>Hypoxemia</u> | | | | | | | | | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF (c) <u>Resumed Septicemia.</u> | | | | | | | | | | | | | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: | | | | | | | | | | | | | |
| 19a DATE OF OPERATION | | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a AUTOPSY? | | 20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? | | | |
| | | | | | | | | YES <input type="checkbox"/> NO <input type="checkbox"/> | | YES <input type="checkbox"/> NO <input type="checkbox"/> | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | 21b. TIME OF INJURY | | | | 21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | | | |
| | | | | HOUR A.M. MONTH DAY YEAR | | | | | | | | | |
| 21d INJURY OCCURRED | | | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | | | 21f LOCATION | | | | | |
| WHITE <input type="checkbox"/> NOT WHITE <input type="checkbox"/> AT WORK <input type="checkbox"/> | | | | | | | | CITY OR TOWN COUNTY STATE | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>2/17/82</u> , 19 <u>82</u> , to <u>2/17/82</u> , 19 <u>82</u> , that (I) (we) lost <u>saw the deceased alive on</u> <u>2/17/82</u> , 19 <u>82</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | | | | | |
| 22b. SIGNATURE | | | | | | | | DEGREE | | ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input checked="" type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> | | 22c DATE SIGNED | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) | | | | | | | | 22e ADDRESS | | | | | |
| DUE LWIN. | | | | | | | | GOOD SAMARITAN HOSP. | | | | | |
| 23a BURIAL, CREMATION, REMOVAL (SPECIFY) | | | | 23b. DATE | | 23c. NAME OF CEMETERY OR CREMATORY | | 23d LOCATION | | | | | |
| Burial | | | | Feb. 20, 1982 | | Holy Redeemer | | Baltimore, Maryland | | | | | |
| 24 FUNERAL DIRECTOR | | | | | | | | 25a. DATE REC'D. BY REGISTRAR | | 25b. REGISTRAR'S SIGNATURE | | | |
| Leonard J. Ruck, Inc. Baltimore, Md. | | | | | | | | FEB 18 1982 | | [Signature] | | | |

11 21 17

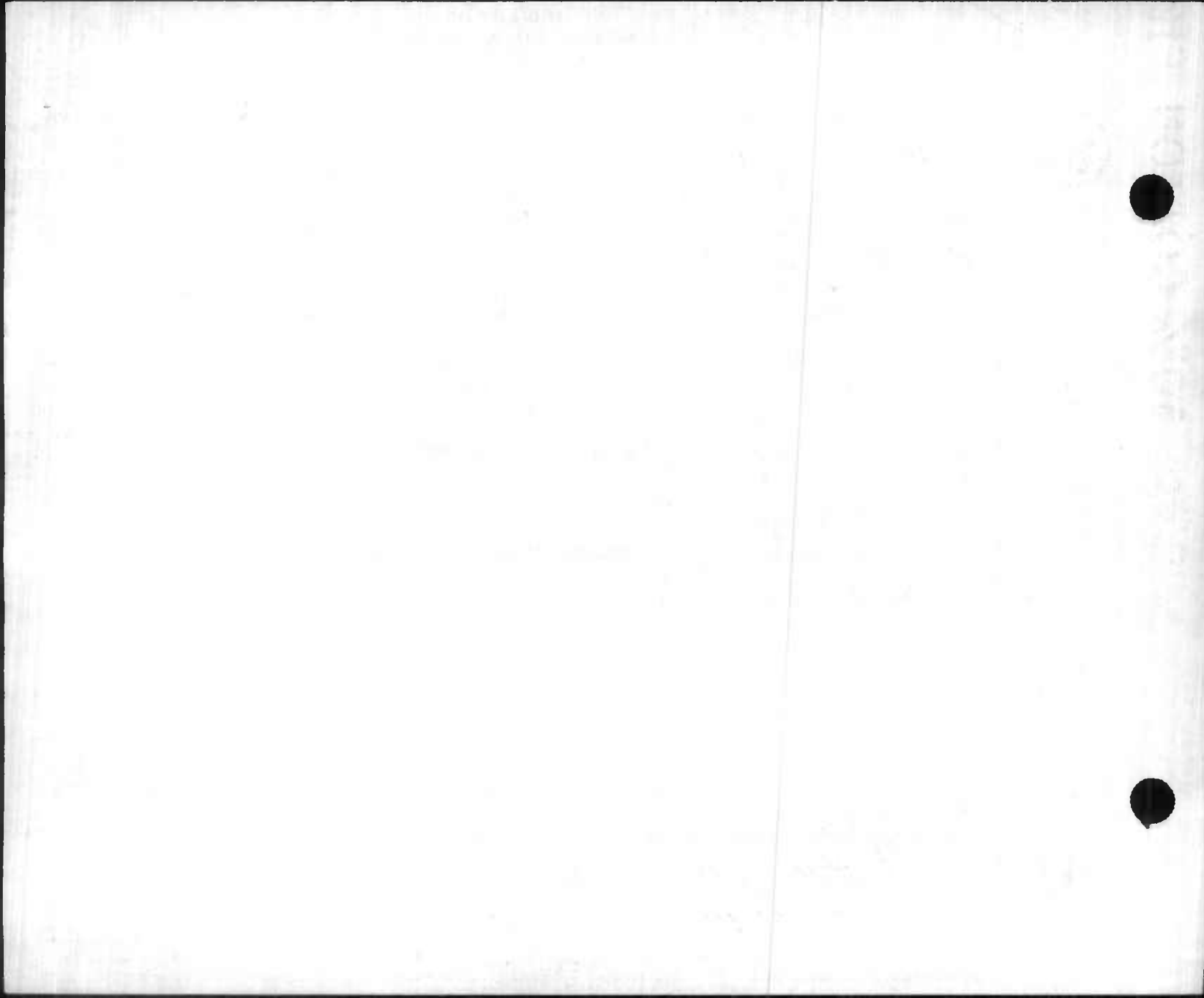
Handwritten notes, possibly a list or description, located in the center of the page.

FOR
1- STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 2 0 3 6 3 4

REG. NO.

| | | | | | | |
|---|--|--|---|---|--|--|
| 1 DECEASED NAME
(TYPE OR PRINT)
FIRST MIDDLE LAST
<i>William Coleman</i> | | | 2a DATE OF DEATH
MONTH DAY YEAR
<i>2 1 82</i> | | 2b HOUR
<i>10:56 AM</i> | |
| 3 SEX
<i>M</i> | | 4 RACE
<i>Black</i> | | 5 DATE OF BIRTH
MONTH DAY YEAR
<i>12 2 02</i> | | |
| 7a BIRTHPLACE
(STATE OR FOREIGN COUNTRY)
<i>Florida</i> | | 7b CITIZEN OF WHAT COUNTRY?
<i>USA</i> | | 6 AGE (IN YEARS LAST BIRTHDAY)
YRS MONTHS DAYS
<i>79</i> | | |
| 10 CITY OR TOWN OF DEATH
<i>Baltimore</i> | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
<i>City Hospital</i> | | 9 BALTIMORE CITY OR COUNTY OF DEATH
<i>Baltimore City</i> MD. | | |
| 12a USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE) | | 12b KIND OF BUSINESS OR INDUSTRY | | | | |
| 13a STATE
<i>MD</i> | | | 13c CITY OR TOWN
<i>Baltimore</i> | | 13d INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 14 FATHER'S NAME
FIRST MIDDLE LAST
<i>- - -</i> | | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
<i>- - -</i> | | | |
| 16a WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)
<i>No</i> | | 16b SOCIAL SECURITY NO.
<i>217-20-8685</i> | | 17 INFORMANT
ADDRESS
<i>Nellie Macey 254 Hartwood Ct.</i> | | |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))
PART 1. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <i>Cardiopulmonary arrest</i>
4151
Conditions, if any, which gave rise to immediate cause (b) <i>possible P.E.</i>
underlying cause last. }
DUE TO, OR AS A CONSEQUENCE OF (b)
DUE TO, OR AS A CONSEQUENCE OF (c) | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:
<i>Chronic renal failure, prostatic cancer</i> | | | | | | |
| 19a DATE OF OPERATION | | 19b CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | |
| 20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | | | | | |
| 21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
<i>P.M. 19</i> | | 21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | |
| 21d INJURY OCCURRED
WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21e PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f LOCATION
STREET CITY OR TOWN COUNTY STATE | | |
| 22a I certify that (I) (this hospital) attended the deceased from <i>2/1</i> 19 <i>82</i> , to <i>2/1</i> 19 <i>82</i> , that (I) (we) last saw the deceased alive on <i>2/1</i> 19 <i>82</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | |
| 22b SIGNATURE
<i>Bruce Kinasin</i> | | DEGREE
ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> | | 22c DATE SIGNED
<i>2/1/82</i> | | |
| 22d PHYSICIAN'S NAME (TYPE OR PRINT)
<i>Bruce Kinasin</i> | | 22e ADDRESS
<i>BCH</i> | | | | |
| 23a BURIAL, CREMATION, REMOVAL (SPECIFY)
<i>Burial</i> | | 23b DATE
<i>2/8/82</i> | | 23c NAME OF CEMETERY OR CREMATORY
<i>Mt. Calvary Cem.</i> | | |
| 23d LOCATION
CITY OR TOWN COUNTY STATE
<i>Baltimore Co. MD</i> | | | | | | |
| 24 FUNERAL DIRECTOR
NAME
<i>Wm. C. March F/H</i> | | ADDRESS
<i>1101 E. North Ave.</i> | | 25a DATE REC'D BY REGISTRAR
<i>FEB 5 1982</i> | | |
| | | 25b REGISTRAR'S SIGNATURE
<i>James J. [Signature]</i> | | | | |

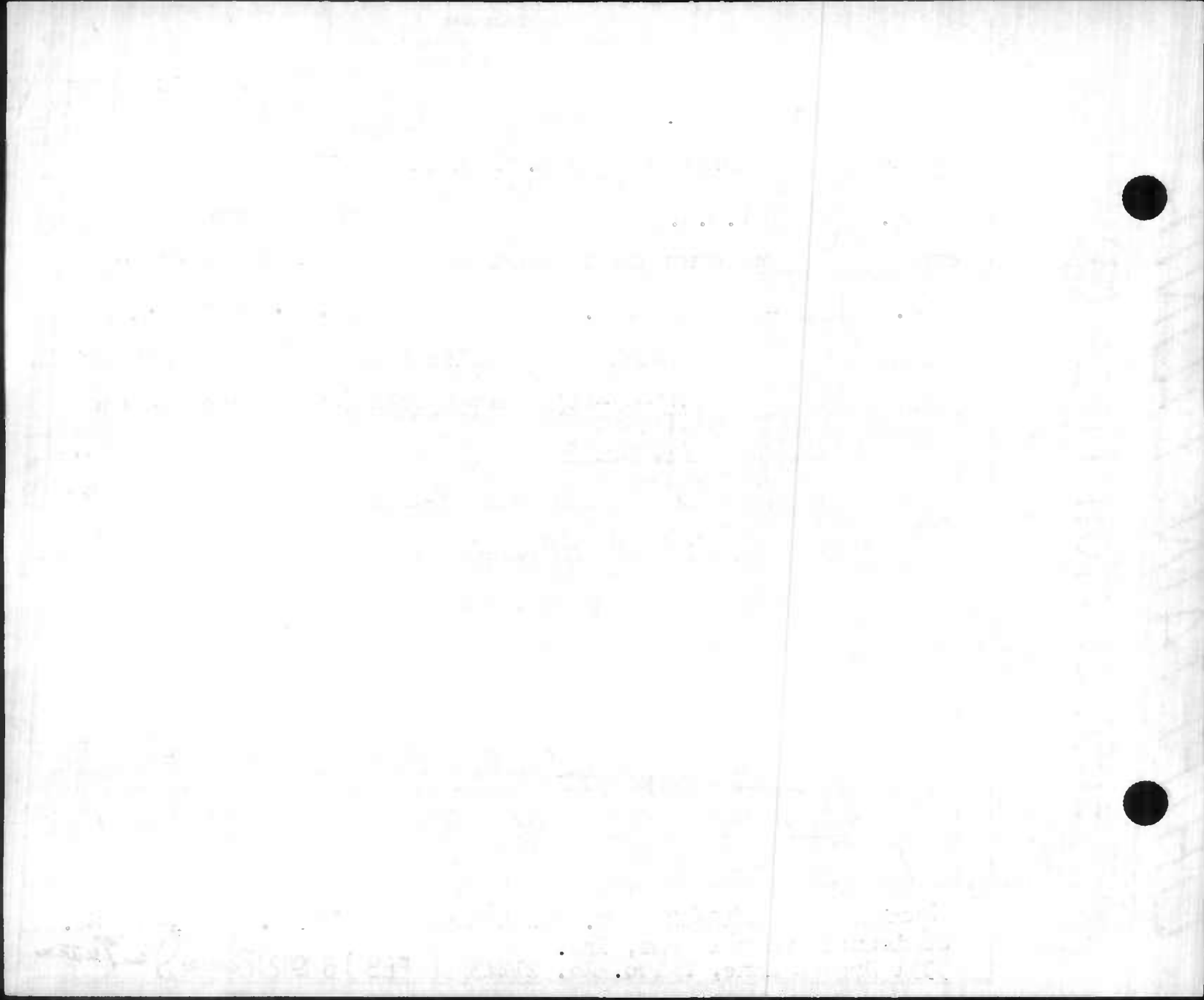


TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be returned within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

6 2 0 3 6 3 5

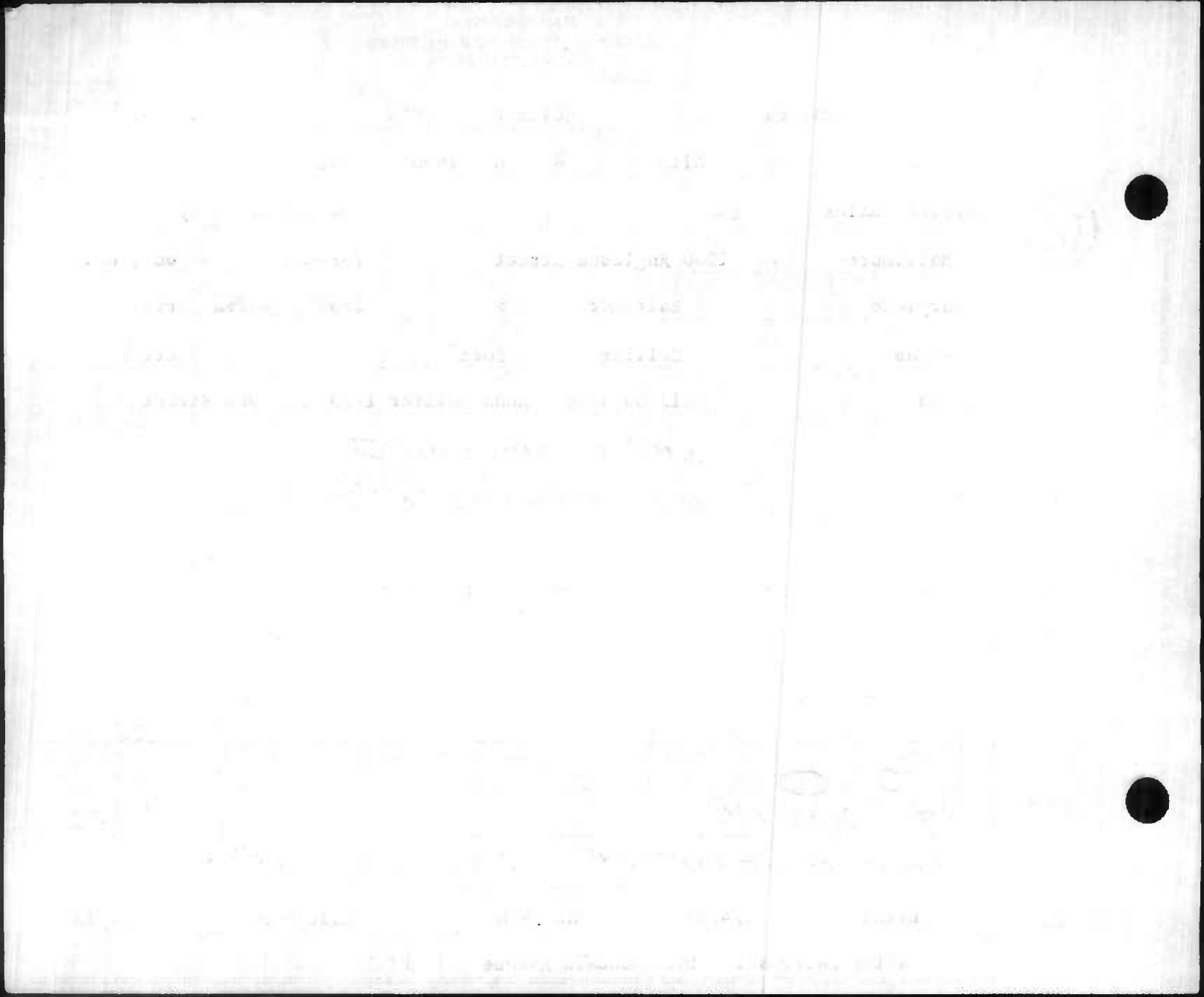
| 1. DECEASED NAME | | 2a. DATE OF DEATH | | 2b. HOUR | |
|---|---------|--|-----|------------------------------------|-------|
| FIRST | LAST | MONTH | DAY | YEAR | |
| JAMES | B. COLL | 02 | 12 | 82 | 5:15A |
| 3. SEX | | 4. RACE | | 5. DATE OF BIRTH | |
| Male | | White | | Jan. 29 1912 | |
| 6. AGE | | 7. IF UNDER 1 YEAR | | 8. IF UNDER 24 HRS | |
| 70 | | MONTHS | | DAYS | |
| 9. BIRTHPLACE | | 10. CITY OR TOWN OF DEATH | | 11. NAME OF HOSPITAL | |
| Md. | | CITY | | THE UNION MEMORIAL HOSPITAL | |
| 12. USUAL RESIDENCE | | 13. STATE | | 14. FATHER'S NAME | |
| Md. | | - | | Leo | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT | |
| no | | 214-03-4156 | | Bertha Coll (wife) same address | |
| 18. CAUSE OF DEATH | | 19. APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | 20. DATE SIGNED | |
| PNEUMONIA | | 2 w. | | 02 12 82 | |
| URINARY TRACT INFECTION | | 4 w. | | | |
| TERMINAL CA OF PROSTATE | | 2 y. | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 | | | | | |
| 21a. DATE OF OPERATION | | 21b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 21c. HOW INJURY OCCURRED | |
| | | | | | |
| 22a. ACCIDENT WAS UNDERLYING | | 22b. TIME OF INJURY | | 22c. LOCATION | |
| OR CONTRIBUTING | | HOUR A.M. MONTH DAY YEAR | | STREET | |
| (IF EITHER, NOTIFY MEDICAL EXAMINER) | | P.M. 19 | | CITY OR TOWN | |
| 23a. INJURY OCCURRED | | 23b. PLACE OF INJURY | | 23c. COUNTY | |
| WHILE AT WORK | | (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | STATE | |
| 24a. I certify that (I) (this hospital) attended the deceased from | | 24b. DATE | | 24c. NAME OF CEMETERY OR CREMATORY | |
| above, (I) (we) (did) (did not) view the body after death | | 2/15/82 | | St. Stanislaus | |
| 25a. SIGNATURE | | 25b. ADDRESS | | 25c. DATE SIGNED | |
| [Signature] | | [Address] | | 02 12 82 | |
| 26a. BURIAL, CREMATION, REMOVAL | | 26b. DATE | | 26c. NAME OF CEMETERY OR CREMATORY | |
| (SPECIFY) | | 2/15/82 | | St. Stanislaus | |
| 27a. FUNERAL HOME OR | | 27b. DATE REC'D. BY REGISTRAR | | 27c. REGISTRAR'S SIGNATURE | |
| NAME | | FEB 16 1982 | | [Signature] | |
| 3331 Brehms Lane, Balto. Md. 21213 | | | | | |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

| STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH | | | | | | | | | | 8 2 0 3 0 3 0 | |
|---|--|---|--|---|--|---|--|--|--|---------------|--|
| 1. FOR STATE REGISTRAR | | REG. NO. | | | | | | | | | |
| 1. DECEASED NAME (TYPE OR PRINT)
FIRST MIDDLE LAST
Charles J Collier | | | | | | 2a. DATE OF DEATH
MONTH DAY YEAR
2 1 82 | | 2b. HOUR
M
 | | | |
| 3. SEX
male | | 4. RACE
white | | 5. DATE OF BIRTH
MONTH DAY YEAR
8 4 1900 | | 6. AGE (IN YEARS LAST BIRTHDAY)
81 | | IF UNDER 1 YEAR
MONTHS DAYS HOURS MIN.
 | | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
Cardiff Whales | | 7b. CITIZEN OF WHAT COUNTRY?
USA | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
Baltimore City MD. | | | | | |
| 10. CITY OR TOWN OF DEATH
Baltimore | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
1230 Angelsea Street | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)
foreman | | 12b. KIND OF BUSINESS OR INDUSTRY
Lock, Ins. G E | | | |
| 13a. STATE
Maryland | | 13b. COUNTY
Baltimore | | 13c. CITY OR TOWN
Baltimore | | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS
1230 Angelsea Street | | | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
Thomas Collier | | | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
Dora Rutter | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)
no | | 16b. SOCIAL SECURITY NO.
213 05 5308 | | 17. INFORMANT
ADDRESS
Anna Collier 1230 Angelsea Street | | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART 1. DEATH WAS CAUSED BY:
1629 IMMEDIATE CAUSE (a) cardiopulmonary arrest
DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b) adeno-metastatic lung carcinoma
DUE TO, OR AS A CONSEQUENCE OF
(c) | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
 | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: chronic obstructive pulmonary disease | | | | | | | | | | | |
| 19a. DATE OF OPERATION
2/2/82 | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED
 | | | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
 P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)
 | | | | | | | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)
 | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE
 | | | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 19 to 19 , that (I) (we) lost saw the deceased above (I) (we) (did) did not view the body after death. | | | | | | | | | | | |
| 22b. SIGNATURE
N. Cutler MD | | | | DEGREE
 | | | | 22c. DATE SIGNED
2/2/82 | | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
NAOMI PAULA CUTLER | | | | 22e. ADDRESS
Baltimore City Hospital | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)
Burial | | 23b. DATE
2/4/82 | | 23c. NAME OF CEMETERY OR CREMATORY
Oak Lawn | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
Baltimore Maryland | | | | | |
| 24. FUNERAL DIRECTOR
NAME
Walter Dabrowski | | | | ADDRESS
1005 Dundalk Avenue | | 25a. DATE REC'D. BY REGISTRAR
FEB 5 1982 | | 25b. REGISTRAR'S SIGNATURE
Thane Jan... | | | |



STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 2 0 3 5 3 7

1- FOR
STATE
REGISTRAR

REG. NO.

| | | | | | |
|---|---|---|---|--|---|
| 1. DECEASED NAME
(TYPE OR PRINT)
MARGARET MARY CONLEY | | | 2a. DATE OF DEATH
MONTH DAY YEAR
FEBRUARY 16, 1982 | | 2b. HOUR
3:16pm |
| 3. SEX
FEMALE | 4. RACE
WHITE | 5. DATE OF BIRTH
MONTH DAY YEAR
3 13 1903 | | 6. AGE (IN YEARS LAST BIRTHDAY)
79 YRS. | IF UNDER 1 YEAR
MONTHS DAYS HOURS MIN. |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
W. VA. | 7b. CITIZEN OF WHAT COUNTRY?
USA | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
BALTO, CITY MD. | |
| 10. CITY OR TOWN OF DEATH
BALTO CITY | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
CHURCH HOME HOSP. | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
H/W | | 12b. KIND OF BUSINESS OR INDUSTRY
- |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)
13a. STATE
MD | | 13b. CITY OR TOWN
BALTO | 13c. INSIDE CITY LIMITS?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | 13d. STREET ADDRESS
35 TOWNSHIP RD. | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
WM SHAFFER | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
MARY JANE BORN | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES NO OR UNKNOWN)
NO | 16b. SOCIAL SECURITY NO.
- | 17. INFORMANT ADDRESS
VIRGIL CONLEY 508 B+A BLVD. | | | |

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART 1. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) **4100 COMPLICATED MYOCARDIAL INFARCTION**

DUE TO, OR AS A CONSEQUENCE OF

Conditions, if any, which
gave rise to immediate
cause (a), stating the
underlying cause last.

(b)

DUE TO, OR AS A CONSEQUENCE OF

(c)

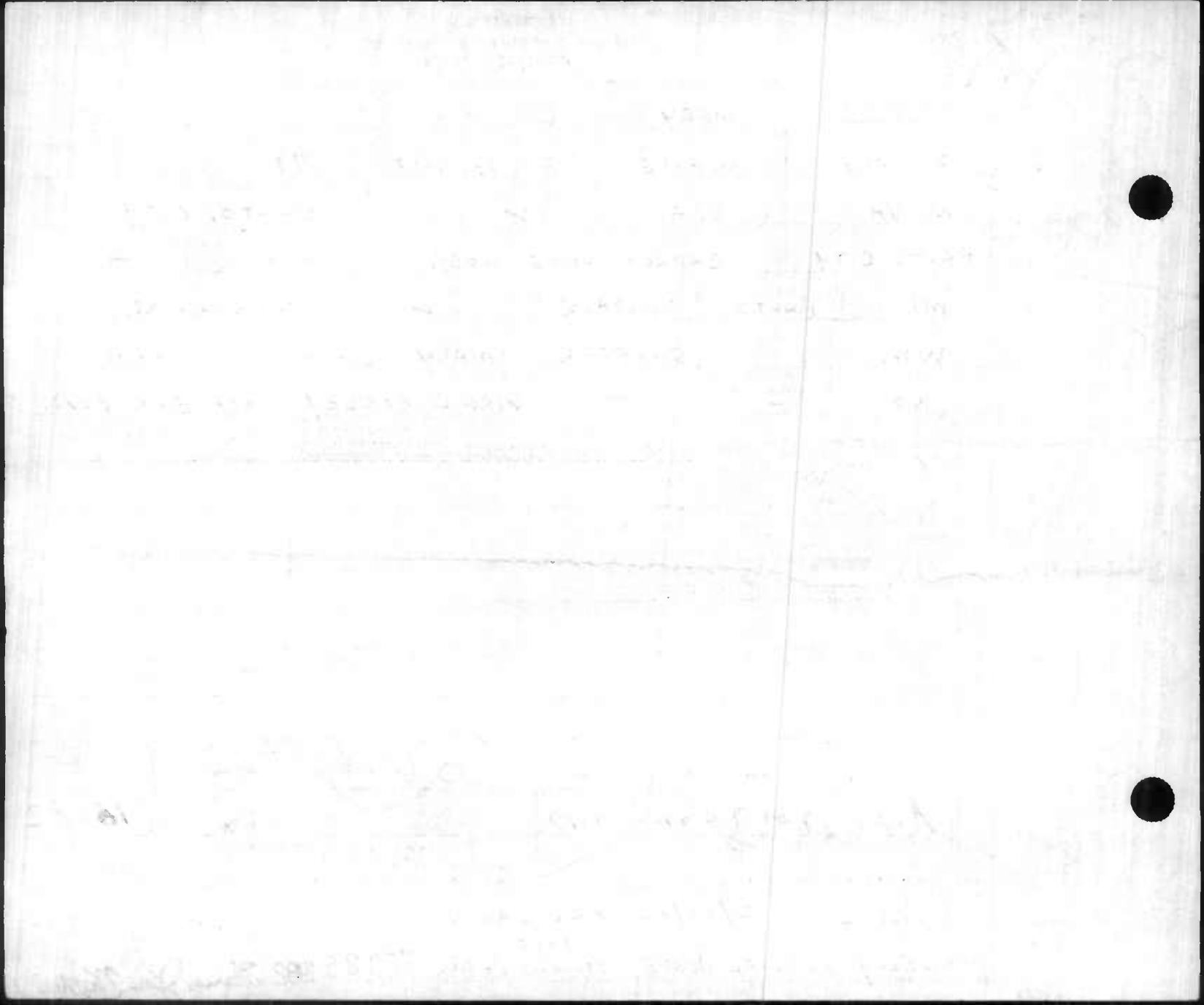
APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATH

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)

CONFESTIVE HEART FAILURE

| | | | |
|---|--|--|---|
| 19a. DATE OF OPERATION | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | 20b. IF YES, WERE FINDINGS USED
IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1b, PART 1 OR PART 2) | |
| 21d. INJURY OCCURRED
WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | |
| 22a. I certify that (I) this hospital attended the deceased from JANUARY 22, 19 82 to FEBRUARY 16, 19 82 , that (I) <input checked="" type="radio"/> saw the deceased alive on above, (I) <input type="radio"/> did not view the body after death, and that in (my) <input checked="" type="radio"/> opinion death occurred on the date and hour and from the causes stated | | | |
| 22b. SIGNATURE
A.P. NAZEMI MD. | | DEGREE
MD | 22c. DATE SIGNED
2/16/82 |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
A.P. NAZEMI MD. | | 22e. ADDRESS
100 NORTH BROADWAY
CHURCH HOME CORP. BALTIMORE, MD; 21231 | |

| | | | |
|--|-----------------------------|---|--|
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)
BURIAL | 23b. DATE
2/20/82 | 23c. NAME OF CEMETERY OR CREMATORY
OAK LAWN | 23d. LOCATION
CITY OR TOWN COUNTY STATE
BALTO MD. |
| 24. FUNERAL DIRECTOR
NAME ADDRESS
CONNELLY FUNERAL HOME 7110 SOLLERS P+ RD. | | 25a. DATE REC'D. BY REGISTRAR
FEB 26 1982 | 25b. REGISTRAR'S SIGNATURE
Francis J. Walker |

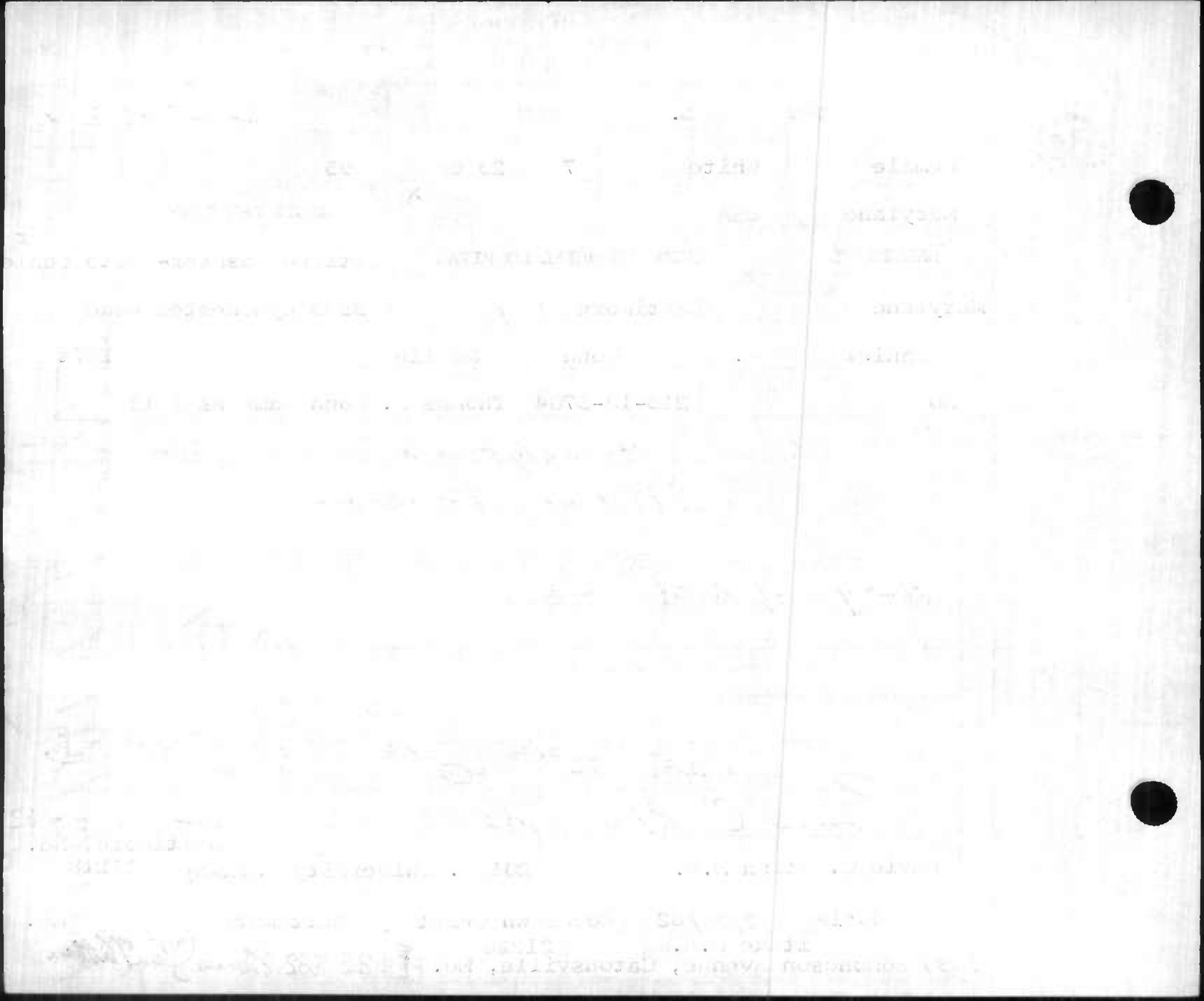


TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH | | | | | | | | | | REG. NO. | |
|---|--|--|--|--|--|---|--|--|--|--------------------------------|--|
| 1. DECEASED NAME
(TYPE OR PRINT)
FIRST MARY MIDDLE L. LAST CONN | | | | | | 2a. DATE OF DEATH
MONTH DAY YEAR
2 23 82 | | 2b. HOUR
2 1M | | | |
| 3. SEX
Female | | 4. RACE
White | | 5. DATE OF BIRTH
MONTH DAY YEAR
7 20 86 | | 6. AGE (IN YEARS LAST BIRTHDAY)
95 YRS. | | IF UNDER 1 YEAR
MONTHS DAYS | | IF UNDER 74 HRS.
HOURS MIN. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
Maryland | | 7b. CITIZEN OF WHAT COUNTRY?
USA | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
BALTIMORE CITY MD. | | | | | |
| 10. CITY OR TOWN OF DEATH
BALTIMORE | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
UNION MEMORIAL HOSPITAL | | | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
Retired Cashier- | | 12b. KIND OF BUSINESS OR INDUSTRY
Auto Dealer | | | |
| 13a. STATE
Maryland | | 13b. COUNTY
Baltimore | | 13c. CITY OR TOWN
Baltimore | | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS
3505 Lynchester Road | | | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
Daniel A. Conn | | | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
Mollie Toft | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
No | | 16b. SOCIAL SECURITY NO.
(IF YES, GIVE WAR OR DATES)
215-10-5704 | | 17. INFORMANT
ADDRESS
Thomas D. Conn Same as # 13 | | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART 1. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>Hypoglycemia</u>
2117
DUE TO, OR AS A CONSEQUENCE OF
(b) <u>Probable Insulinoma</u>
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO, OR AS A CONSEQUENCE OF
(c) _____
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:
<u>History of Rectal Ca</u> | | | | | | | | | | | |
| 19a. DATE OF OPERATION
<u>2/23</u> | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | | | | | |
| 21d. INJURY OCCURRED
WHERE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>2/22</u> 19 <u>82</u> to <u>2/23</u> 19 <u>82</u> , that (I) (we) last saw the deceased alive on <u>2/23</u> 19 <u>82</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | | | |
| 22b. SIGNATURE
<u>David C. Allen</u> | | | | DEGREE
MD | | | | 22c. DATE SIGNED
<u>2/24/82</u> | | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
David C. Allen M.D. | | | | 22e. ADDRESS
Baltimore, Md.
201 E. University Parkway 21218 | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)
Burial | | 23b. DATE
2/26/82 | | 23c. NAME OF CEMETERY OR CREMATORY
Woodlawn Cemetery | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
Baltimore Md. | | | | | |
| 24. FUNERAL DIRECTOR
NAME ADDRESS
Witake P.A. 21228
1630 Edmondson Avenue, Catonsville, Md. | | | | 25a. DATE REC'D. BY REGISTRAR
FEB 25 1982 | | | | | | | |
| | | | | 25b. REGISTRAR'S SIGNATURE
<u>Frances Jean Mathews</u> | | | | | | | |



STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

6 2 0 3 6 3 9

| | | | |
|---|--|---|--|
| 1. FOR STATE REGISTRAR | | REG. NO. | |
| 1 DECEASED NAME
(TYPE OR PRINT)
JANICE CONNER | | 2a DATE OF DEATH
MONTH DAY YEAR
FEBRUARY 18, 1982 | |
| 3 SEX
Female | | 2b HOUR
2:45 AM | |
| 4 RACE
White | | 6 AGE (IN YEARS LAST BIRTHDAY)
68 | |
| 5 DATE OF BIRTH
MONTH DAY YEAR
Dec. 9, 1913 | | 8 IF UNDER 1 YEAR
MONTHS DAYS HOURS MIN.
YRS | |
| 7a BIRTHPLACE (STATE OR FOREIGN COUNTRY)
Pa. | | 7b CITIZEN OF WHAT COUNTRY?
USA | |
| 10 CITY OR TOWN OF DEATH
Baltimore | | 9 BALTIMORE CITY OR COUNTY OF DEATH
BALTIMORE CITY MD. | |
| 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
JOHNS HOPKINS HOSPITAL | | 12a USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
Nurse | |
| 12b KIND OF BUSINESS OR INDUSTRY
Nursing | | | |
| 13a STATE
Maryland | | 13b COUNTY
Baltimore | |
| 13c CITY OR TOWN
Baltimore | | 13d INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 13e STREET ADDRESS
219 E. Montgomery St. | | | |
| 14 FATHER'S NAME
FIRST MIDDLE LAST
Marvin E. Conner | | 15 MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
Josephine Pursel | |
| 16a WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
No | | 16b SOCIAL SECURITY NO.
180 26 1180 | |
| 17 INFORMANT
Miss Phyllis Conner | | ADDRESS
Same | |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART 1. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) CARDIO RESPIRATORY ARREST
1749
DUE TO, OR AS A CONSEQUENCE OF
(b) HEPATIC ENCEPHALOPATHY
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(c) METASTATIC BREAST CANCER TO LIVER/BONE 2 MOS
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
5 MINUTES
8 DAYS | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)
HYPERURICEMIA | | | |
| 19a DATE OF OPERATION | | 19b CONDITION FOR WHICH OPERATION WAS PERFORMED | |
| 20a AUTOPSY?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER NOTIFY MEDICAL EXAMINER) | | 21b TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | |
| 21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) | | | |
| 21d INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/> | | 21e PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | |
| 21f LOCATION
STREET CITY OR TOWN COUNTY STATE | | | |
| 22a I certify that (a) (this hospital) attended the deceased from FEB 11 , 19 82 , to FEB 18 , 19 82 , that (b) (we) last saw the deceased alive on FEB 18 , 19 82 , and that in (c) (our) opinion death occurred on the date and hour and from the causes stated above. (d) (we) (did) (did not) view the body after death. | | | |
| 22b SIGNATURE
[Signature] | | DEGREE
ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> | |
| 22c DATE SIGNED
2/18/82 | | | |
| 22d PHYSICIAN'S NAME (TYPE OR PRINT)
ANASTASIO R. DE CASTRO | | 22e ADDRESS
80 HRS HOPKINS HOSPITAL | |
| 23a BURIAL, CREMATION, REMOVAL
(SPECIFY)
Cremation | | 23b DATE
2/19/82 | |
| 23c NAME OF CEMETERY OR CREMATORY
Green Mount | | 23d LOCATION
CITY OR TOWN COUNTY STATE
Balto., Md. | |
| 24 FUNERAL DIRECTOR
NAME
Henry W. Jenkins & Sons Co.
ADDRESS
4905 York Road Balto., Md. 21212 | | 25a DATE REC'D. BY REGISTRAR
FEB 22 1982 | |
| 25b REGISTRAR'S SIGNATURE
[Signature] | | | |

154

j

11-21

1951-1952

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

6 2 0 3 6 4 0

FOR
1 - STATE
REGISTRAR

REG. NO.

| | | | | | |
|---|--|---|--|---|--|
| 1. DECEASED NAME (TYPE OR PRINT)
Thomas F. Connolly | | 2a. DATE OF DEATH
MONTH DAY YEAR
2 11 82 | | 2b. HOUR
1 P | |
| 3. SEX
MALE | 4. RACE
WHITE | 5. DATE OF BIRTH
MONTH DAY YEAR
6 26 10 | | 6. AGE (IN YEARS LAST BIRTHDAY)
71 YRS | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
BALT | 7b. CITIZEN OF WHAT COUNTRY?
USA | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
BALT, CITY MD. | |
| 10. CITY OR TOWN OF DEATH
BALTIMORE | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
Mercy Hospital | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
RETIRED - MTA | | 12b. KIND OF BUSINESS OR INDUSTRY |
| 13a. STATE
Md. | | 13b. COUNTY
- | 13c. CITY OR TOWN
Balto. | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
Thomas Connolly | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
Blanche Phillips | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN) - | | 16b. SOCIAL SECURITY NO.
216-03-5142 | | 17. INFORMANT ADDRESS
Mary Connolly, 4214 Heckel Ave. 21206 | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Renal Failure
1850
DUE TO, OR AS A CONSEQUENCE OF
(b) RENAL CARCINOMA
DUE TO, OR AS A CONSEQUENCE OF
(c) CARCINOMA OF PROSTATE | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
2 wks
YEARS
YEARS |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I.
PULMONARY CONGESTION | | | | | |
| 19a. DATE OF OPERATION
11/13/82 | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED
RIGHT NEPHRECTOMY | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK AT WORK | | 21e. PLACE OF INJURY
(AT HOME STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | |
| 22a. I certify that (1) (this hospital) attended the deceased from 11/11/82 to 2/11/82 , that (we) last saw the deceased alive on 2/11/82 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death. | | | | | |
| 22b. SIGNATURE
[Signature] | | DEGREE
MD | | 22c. DATE SIGNED
2/11/82 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
ZIMMERMAN | | 22e. ADDRESS
Mercy Hospital | | | |
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)
Burial | | 23b. DATE
2/15/82 | | 23c. NAME OF CEMETERY OR CREMATORY
Glen Haven Cemetery | |
| 23d. LOCATION
(CITY OR TOWN)
Baltimore, Maryland | | 23e. DATE REC'D. BY REGISTRAR
FEB 16 1982 | | | |
| 24. FUNERAL DIRECTOR
Schmittnek Funeral Home, Inc.
3331 Brehms Lane, Balto., Md. 21213 | | 25b. REGISTRAR'S SIGNATURE
[Signature] | | | |

FEB 16 1985

TO HOSPITAL, ATTENDING PHYSICIAN. The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR. After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 1 and 2 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

DHMH-16 20M
(VRA 15, 4) 7/78

FOR
1 - STATE
REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 2 0 3 6 4 1

REG. NO.

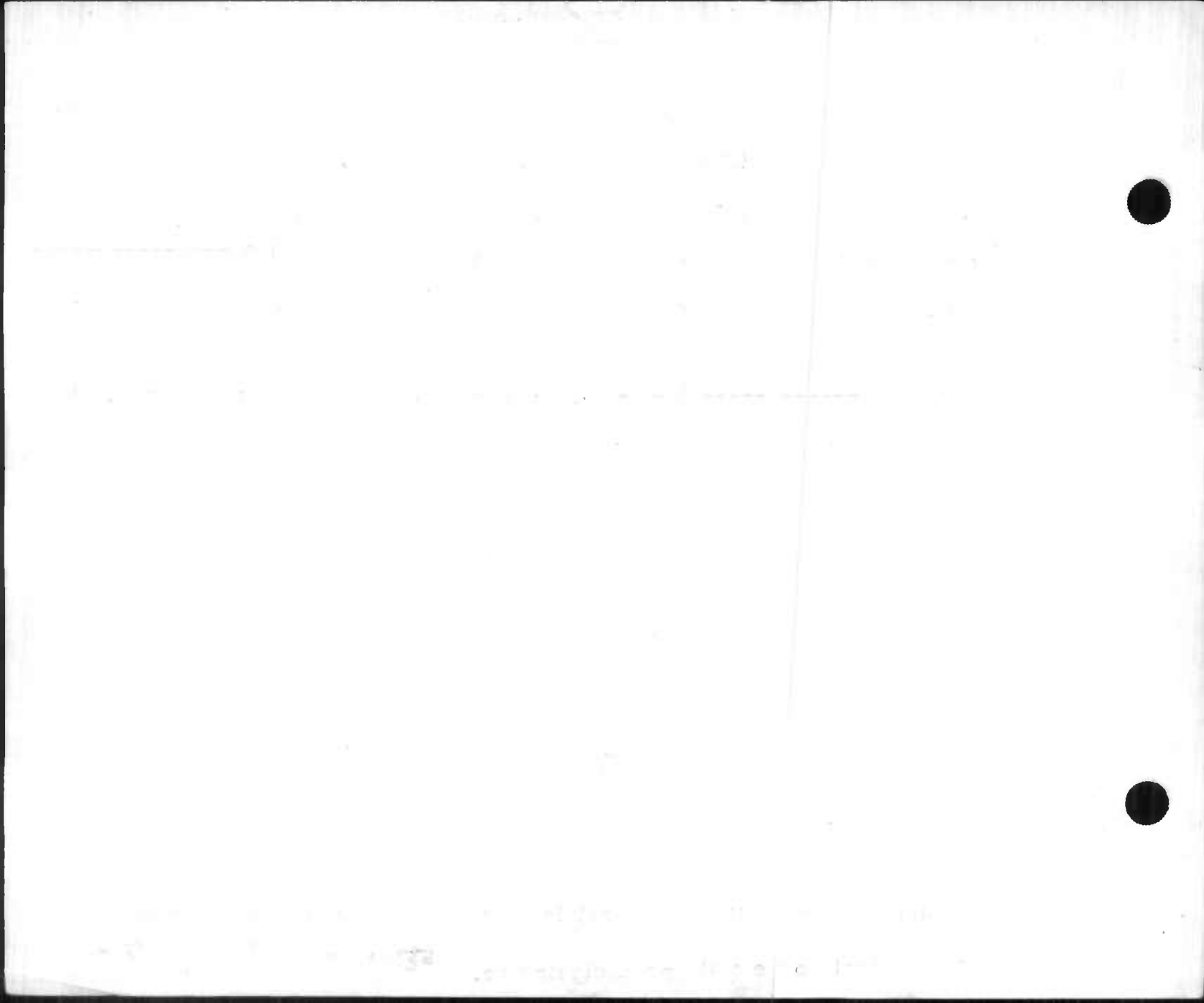
| | | | | | |
|---|--|---|---|--|---|
| 1. DECEASED NAME
(TYPE OR PRINT)
ELMER CONWAY | | | 2a. DATE OF DEATH
MONTH DAY YEAR
2/5/82 | | 2b. HOUR
5:00 AM |
| 3. SEX
MALE | 4. RACE
White | 5. DATE OF BIRTH
MONTH DAY YEAR
11 28 20 | 6. AGE (IN YEARS LAST BIRTHDAY)
61 YRS. | IF UNDER 1 YEAR
MONTHS DAYS
IF UNDER 24 HRS
HOURS MIN. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
Md. | 7b. CITIZEN OF WHAT COUNTRY?
USA | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 9. BALTIMORE CITY OR COUNTY OF DEATH
BALTIMORE CITY MD. | | |
| 10. CITY OR TOWN OF DEATH
BALTIMORE | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
MT. SINAI NSG. HOME | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
Retired | 12b. KIND OF BUSINESS OR INDUSTRY | |
| 13a. STATE
MD. | 13b. COUNTY | 13c. CITY OR TOWN
BALT. | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | 13e. STREET ADDRESS
3520 HILTON RD. 21215 | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
YES | | 16b. SOCIAL SECURITY NO.
--218-18-1908 | | 17. INFORMANT
ADDRESS
DOROTHY GILLESPIE 2686 Eagle St. 21223 | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY
IMMEDIATE CAUSE (a) SEPSIS
4860
DUE TO, OR AS A CONSEQUENCE OF
(b) PNEUMONIA
DUE TO, OR AS A CONSEQUENCE OF
(c) | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)
ACUTE PEPTIC ULCER | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input type="checkbox"/> | 20b. IF YES, WERE FINDINGS USED
IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK AT WORK | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | |
| 22a. I certify that (I) (this hospital) attended the deceased from JANUARY 12, 1982, to February 4, 1982, that (I) (we) last saw the deceased alive on February 4, 1982, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death. | | | | | |
| 22b. SIGNATURE
[Signature] | | DEGREE
ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | 22c. DATE SIGNED
2/5/82 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
[Signature] | | 22e. ADDRESS
3640 Fuchs Lane 21215 | | | |
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)
Burial? Cremat | 23b. DATE
2/11/82 | 23c. NAME OF CEMETERY OR CREMATORY
Westview Mem Pk/ | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
Baltimore, Maryland | |
| 24. FUNERAL DIRECTOR
NAME
Law Funeral Home 4611 Park Heights Ave. | | ADDRESS | | 25a. DATE REC'D. BY REGISTRAR
FEB 11 1982 | |
| | | | | 25b. REGISTRAR'S SIGNATURE
[Signature] | |

35
70
35
300

MEDICAL CERTIFICATION

9
9

1511



TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM-3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITH YOUR FILES AFTER DEATH. WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP

DHMH - 17
(VR A15 ME (5))
15M 2/80

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | | | | | |
|--|--|--|--|--|--|---------------------------------------|--|---------------------------------------|--|---------------------|--|
| 1. FOR STATE REGISTRAR | | 2. DATE KNOWN OF DEATH | | 3. MONTH | | 4. DAY | | 5. YEAR | | 6. HOUR | |
| 1. DECEASED NAME (TYPE OR PRINT) | | 2. DATE KNOWN OF DEATH | | 3. MONTH | | 4. DAY | | 5. YEAR | | 6. HOUR | |
| DONALD E. COOK | | 2. DATE KNOWN OF DEATH | | 3. MONTH | | 4. DAY | | 5. YEAR | | 6. HOUR | |
| 7. BIRTHPLACE (STATE OR FOREIGN COUNTRY) | | 8. MARRIED | | 9. NEVER MARRIED | | 10. DIVORCED | | 11. BALTIMORE CITY OR COUNTY OF DEATH | | 12. HOUR | |
| Maryland | | 8. MARRIED | | 9. NEVER MARRIED | | 10. DIVORCED | | 11. BALTIMORE CITY OR COUNTY OF DEATH | | 12. HOUR | |
| 10. CITY OR TOWN OF DEATH | | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION | | 12. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | | 13. KIND OF BUSINESS OR INDUSTRY | | 14. BALTIMORE CITY OR COUNTY OF DEATH | | 15. HOUR | |
| Baltimore | | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION | | 12. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | | 13. KIND OF BUSINESS OR INDUSTRY | | 14. BALTIMORE CITY OR COUNTY OF DEATH | | 15. HOUR | |
| University Hospital | | 12. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | | 13. KIND OF BUSINESS OR INDUSTRY | | 14. BALTIMORE CITY OR COUNTY OF DEATH | | 15. HOUR | | 16. HOUR | |
| Production Line | | 13. KIND OF BUSINESS OR INDUSTRY | | 14. BALTIMORE CITY OR COUNTY OF DEATH | | 15. HOUR | | 16. HOUR | | 17. HOUR | |
| Pepsi-Cola | | 14. BALTIMORE CITY OR COUNTY OF DEATH | | 15. HOUR | | 16. HOUR | | 17. HOUR | | 18. HOUR | |
| Pasadena | | 15. HOUR | | 16. HOUR | | 17. HOUR | | 18. HOUR | | 19. HOUR | |
| 16. STATE | | 17. COUNTY | | 18. CITY OR TOWN | | 19. STREET ADDRESS | | 20. INSIDE CITY LIMITS? | | 21. STREET ADDRESS | |
| Maryland | | 17. COUNTY | | 18. CITY OR TOWN | | 19. STREET ADDRESS | | 20. INSIDE CITY LIMITS? | | 21. STREET ADDRESS | |
| Anne Arundel | | 18. CITY OR TOWN | | 19. STREET ADDRESS | | 20. INSIDE CITY LIMITS? | | 21. STREET ADDRESS | | 22. STREET ADDRESS | |
| Pasadena | | 19. STREET ADDRESS | | 20. INSIDE CITY LIMITS? | | 21. STREET ADDRESS | | 22. STREET ADDRESS | | 23. STREET ADDRESS | |
| 309 Green Drive | | 20. INSIDE CITY LIMITS? | | 21. STREET ADDRESS | | 22. STREET ADDRESS | | 23. STREET ADDRESS | | 24. STREET ADDRESS | |
| 309 Green Drive | | 21. STREET ADDRESS | | 22. STREET ADDRESS | | 23. STREET ADDRESS | | 24. STREET ADDRESS | | 25. STREET ADDRESS | |
| 309 Green Drive | | 22. STREET ADDRESS | | 23. STREET ADDRESS | | 24. STREET ADDRESS | | 25. STREET ADDRESS | | 26. STREET ADDRESS | |
| 309 Green Drive | | 23. STREET ADDRESS | | 24. STREET ADDRESS | | 25. STREET ADDRESS | | 26. STREET ADDRESS | | 27. STREET ADDRESS | |
| 309 Green Drive | | 24. STREET ADDRESS | | 25. STREET ADDRESS | | 26. STREET ADDRESS | | 27. STREET ADDRESS | | 28. STREET ADDRESS | |
| 309 Green Drive | | 25. STREET ADDRESS | | 26. STREET ADDRESS | | 27. STREET ADDRESS | | 28. STREET ADDRESS | | 29. STREET ADDRESS | |
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| 309 Green Drive | | 87. STREET ADDRESS | | 88. STREET ADDRESS | | 89. STREET ADDRESS | | 90. STREET ADDRESS | | 91. STREET ADDRESS | |
| 309 Green Drive | | 88. STREET ADDRESS | | 89. STREET ADDRESS | | 90. STREET ADDRESS | | 91. STREET ADDRESS | | 92. STREET ADDRESS | |
| 309 Green Drive | | 89. STREET ADDRESS | | 90. STREET ADDRESS | | 91. STREET ADDRESS | | 92. STREET ADDRESS | | 93. STREET ADDRESS | |
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| 309 Green Drive | | 91. STREET ADDRESS | | 92. STREET ADDRESS | | 93. STREET ADDRESS | | 94. STREET ADDRESS | | 95. STREET ADDRESS | |
| 309 Green Drive | | 92. STREET ADDRESS | | 93. STREET ADDRESS | | 94. STREET ADDRESS | | 95. STREET ADDRESS | | 96. STREET ADDRESS | |
| 309 Green Drive | | 93. STREET ADDRESS | | 94. STREET ADDRESS | | 95. STREET ADDRESS | | 96. STREET ADDRESS | | 97. STREET ADDRESS | |
| 309 Green Drive | | 94. STREET ADDRESS | | 95. STREET ADDRESS | | 96. STREET ADDRESS | | 97. STREET ADDRESS | | 98. STREET ADDRESS | |
| 309 Green Drive | | 95. STREET ADDRESS | | 96. STREET ADDRESS | | 97. STREET ADDRESS | | 98. STREET ADDRESS | | 99. STREET ADDRESS | |
| 309 Green Drive | | 96. STREET ADDRESS | | 97. STREET ADDRESS | | 98. STREET ADDRESS | | 99. STREET ADDRESS | | 100. STREET ADDRESS | |

MEDICAL CERTIFICATION

18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Thoraco-abdominal injuries
DUE TO, OR AS A CONSEQUENCE OF
(b) _____
DUE TO, OR AS A CONSEQUENCE OF
(c) _____

PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).

19a. DATE OF OPERATION

19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?

20. AUTOPSY?

YES ☒ NO ☐

21a. EXTERNAL CAUSE WAS

UNDERLYING ☒ OR
CONTRIBUTING ☐ CAUSE OF DEATH21b. TIME OF INJURY
HOUR 4:07 P.M. 2-5 1982

21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)

Driver in auto/auto collision.

21d. INJURY OCCURRED

WHILE ☐ NOT WHILE ☒
AT WORK AT WORK21e. PLACE OF INJURY (AT HOME,
STREET, FACTORY, FARM, ETC.)

road

21f. LOCATION

Ritchie Hwy. no. of Arnold Anne Arundel Md.
Chaptaugua Rd.

22a. I certify that I took charge of the remains described above, held an

death resulted from: Natural causes ☐ Accident ☒ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL
SIGNATURE

TITLE (SPECIFY)

M.D. Assistant MEDICAL EXAMINER

DATE
SIGNED 2-6-82EXAMINER'S NAME
(TYPE OR PRINT)

Ann M. Dixon, M.D.

ADDRESS 111 Penn St.

23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)

Burial

23b. DATE

Feb. 9, 1982

23c. NAME OF CEMETERY OR CREMATORY

Lake View Memorial Park

23d. LOCATION

Syresville

COUNTY

Maryland

24. FUNERAL DIRECTOR

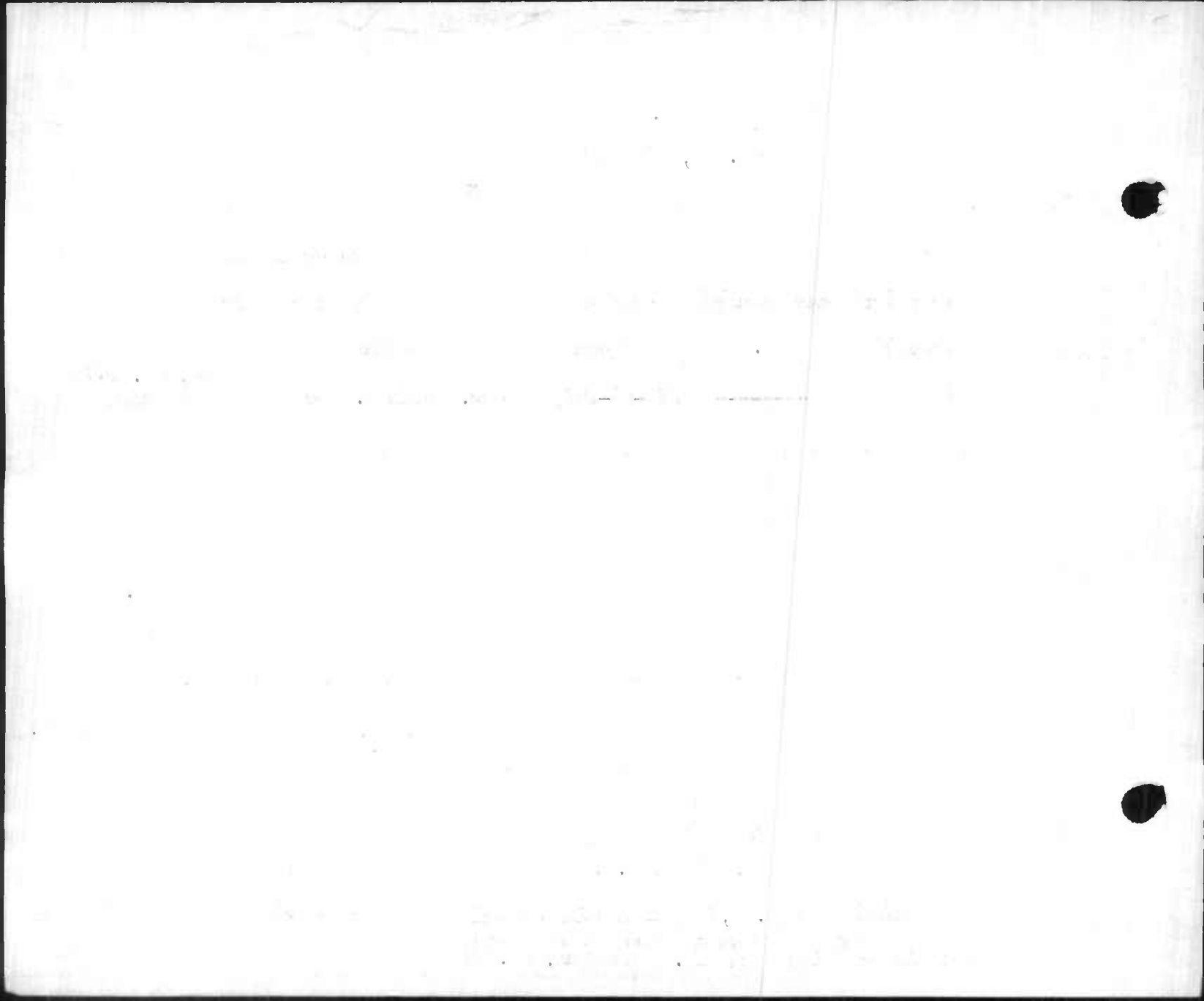
McCully Funeral Home of Pasadena
Mountain and Tick Neck Rds. Pasadena, Md. 21122

25a. DATE REC'D. BY REGISTRAR

FEB 10 1982

25b. REGISTRAR'S SIGNATURE

Ann M. Dixon

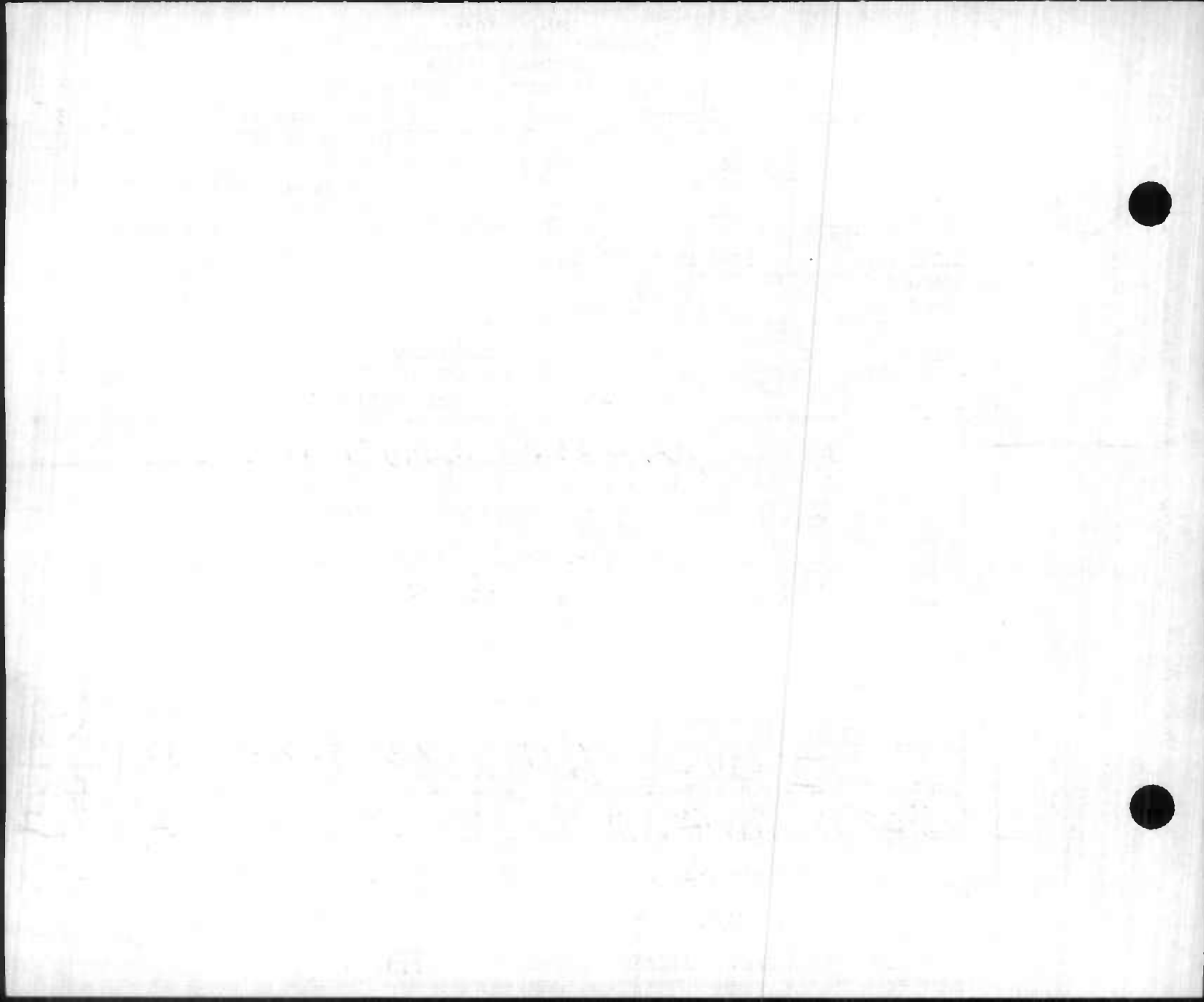


TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be released by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use on the burial/interment permit. These permits remove carbon copies. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of same.

| STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH | | | | | | | | | | REG. NO. 8 2 0 3 6 4 3 | | | | | |
|---|--|--|--|--|--|--|--|--|---|--|--|--|--|--|--|
| 1. DECEASED NAME
(TYPE OR PRINT)
FIRST MIDDLE LAST
Sarah Milbrough Cook | | | | | | | | | | 2a. DATE OF DEATH
MONTH DAY YEAR
February 4, 1982 | | | | 2b. HOUR
8:00 A.M. | |
| 3. SEX
Female | | 4. RACE
White | | 5. DATE OF BIRTH
MONTH DAY YEAR
Dec 4, 1891 | | | 6. AGE (IN YEARS LAST BIRTHDAY)
90 | | 7. IF UNDER 1 YEAR
MONTHS DAYS
YES | | 8. IF UNDER 24 HRS
HOURS MIN.
YES | | | | |
| 9a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
Maryland | | 9b. CITIZEN OF WHAT COUNTRY?
U.S.A. | | 10. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | | 9. BALTIMORE CITY OR COUNTY OF DEATH
Baltimore City MD | | | | | | | | |
| 10. CITY OR TOWN OF DEATH
Baltimore | | | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
3800 Eastwood Drive | | | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
Housewife | | | 12b. KIND OF BUSINESS OR INDUSTRY | | | | |
| 13a. STATE
Maryland | | 13b. COUNTY | | 13c. CITY OR TOWN
Baltimore | | 13d. INSIDE CITY (LIMITS)
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS
3800 Eastwood Drive | | | | | | | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
Frank C Whiteford | | | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
Katherine M Bee | | | | | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
No | | 16b. SOCIAL SECURITY NO.
(IF YES, GIVE YEAR OR DATES)
219-56-4907 | | 17. INFORMANT
ADDRESS
Mrs Doris M Dietrich | | | | 17b. Same | | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART 1. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): ABAND - acute MI.
4100
DUE TO, OR AS A CONSEQUENCE OF (b):
Conditions, if any, which gave rise to immediate cause (b), stating the underlying cause last:
DUE TO, OR AS A CONSEQUENCE OF (c): | | | | | | | | | | | | APPROPRIATE INTERVAL BETWEEN ONSET AND DEATH | | | |
| PART 2. OTHER SIGNS AND CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a):
Phenitoid Spongle | | | | | | | | | | | | | | | |
| 19a. DATE OF OPERATION
9/11 | | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED
Phenitoid Spongle | | | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF OTHER, NOTIFY MEDICAL EXAMINER) | | | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
9/11 1982 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | | | | | | | |
| 21d. INJURY OCCURRED:
WHILE AT WORK <input type="checkbox"/> NOT AT WORK <input checked="" type="checkbox"/> | | | | 21e. PLACE OF INJURY
(IF HOME, STREET, FACTORY, OFFICE, Etc.)
3800 Eastwood Drive | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE
3800 Eastwood Drive Baltimore City MD | | | | | | | | | |
| 22. I certify that (I) (this hospital) attended the deceased from 9/11 19 82 to Feb 4 19 82 that (I) (we) last saw the deceased alive on Feb 2 19 82 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (add) (delete) view the body after death. | | | | | | | | | | | | | | | |
| 23a. SIGNATURE
Donald W. Mintzer M.D. | | | | DEGREE
M.D. | | | | 23b. DATE SIGNED
2/5/82 | | | | | | | |
| 23c. PHYSICIAN'S NAME (TYPE OR PRINT)
Donald W Mintzer M.D. | | | | 23d. ADDRESS
3009 Evergreen Ave Baltimore, Maryland | | | | | | | | | | | |
| 24a. BURIAL, CREMATION, REMOVAL
(TYPE)
Burial | | | | 24b. DATE
2/8/82 | | 24c. NAME OF CEMETERY OR CREMATORY
Loudon Park | | | | 24d. LOCATION
CITY OR TOWN COUNTY STATE
Baltimore, Maryland | | | | | |
| 25. FUNERAL DIRECTOR
NAME ADDRESS
Leonard J Ruck Inc. Baltimore, Maryland | | | | | | 25a. DATE REC'D. BY REGISTRAR
FEB 8 1982 | | | | | | | | 25b. REGISTRAR'S SIGNATURE
Thomas J. [Signature] | |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

| STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH | | | | REG. NO. | | | |
|---|--|--|--|---|-----------------------------------|--|-----------------------------|
| 1. DECEASED NAME (TYPE OR PRINT) RAYMOND COOK | | | | 2a. DATE OF DEATH MONTH DAY YEAR 2/15/82 | | 2b. HOUR 830 P.M. | |
| 3 SEX Male | 4 RACE Black | 5 DATE OF BIRTH MONTH DAY YEAR 1/27/38 | 6 AGE (IN YEARS LAST BIRTHDAY) 44 | | IF UNDER 1 YEAR MONTHS DAYS | | IF UNDER 24 HRS. HOURS MIN. |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MD. | 7b. CITIZEN OF WHAT COUNTRY? USA | 8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 9 BALTIMORE CITY OR COUNTY OF DEATH Balto City MD. | | | | |
| 10 CITY OR TOWN OF DEATH Balto. | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Balto. City Hospital | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | | 12b. KIND OF BUSINESS OR INDUSTRY | | |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE MD. | 13b. CITY City | 13c. CITY OR TOWN Balto. | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | 13e. STREET ADDRESS 5205 Frankford Ave. | | | |
| 14 FATHER'S NAME FIRST MIDDLE LAST Raymond Wheatley | | 15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Amanda Cook | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No | 16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 216-34-6270 | 17 INFORMANT ADDRESS 5205 Shirley Cook Frankford Ave Apt.B | | | | | |
| 18 CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) 4275 cardiopulmonary arrest
DUE TO, OR AS A CONSEQUENCE OF (b) _____
Conditions, if any, which gave rise to immediate cause (c) stopping the underlying cause lost
DUE TO, OR AS A CONSEQUENCE OF (d) _____
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (e) intracerebral bleed | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| 19a. DATE OF OPERATION | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | 20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | | | |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 12/19/81 to 2/15/82 19____ that (I) (we) lost above (I) (we) (did) (did not) view the body after death. | | | | | | | |
| 22b. SIGNATURE CRIBBIN | | DEGREE MD | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | 22c. DATE SIGNED 2/15/82 | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) | | 22e. ADDRESS BCTH | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | 23b. DATE 2/20/82 | 23c. NAME OF CEMETERY OR CREMATORY Mt Auburn | | 23d. LOCATION CITY OR TOWN COUNTY STATE Westport Md. | | | |
| 24 FUNERAL DIRECTOR NAME Chas. A. Rice FSPA | | ADDRESS 1300 Eutaw Pl. | | 25a. DATE REC'D. BY REGISTRAR FEB 17 1982 | | 25b. REGISTRAR'S SIGNATURE James J. Smith | |

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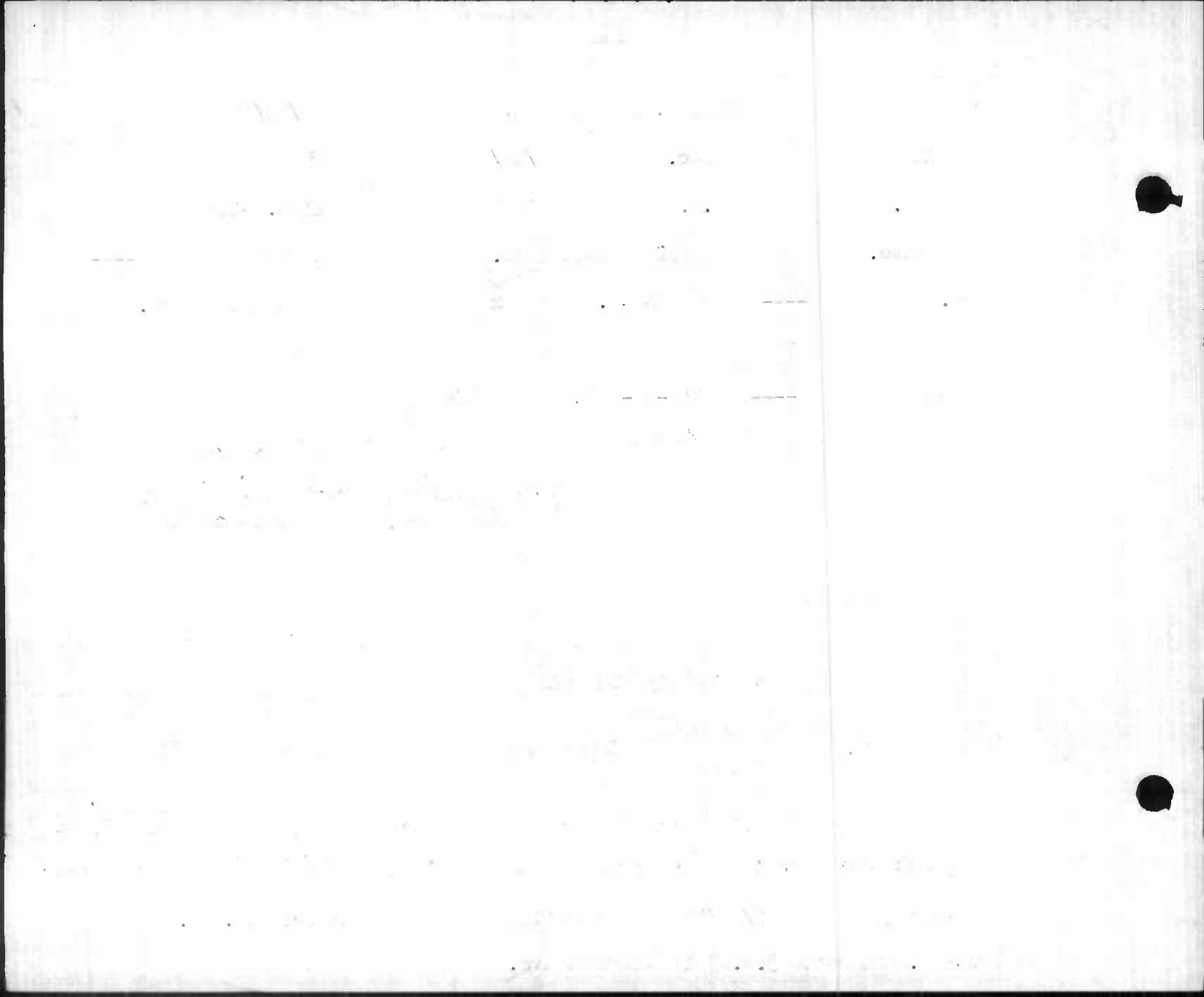
FEB 11 1943

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 should be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH | | | | | | | | | |
|---|--|--|---|--|--|---|--|---|--|
| 1. FOR STATE REGISTRAR | | | | | 8 2 0 3 5 4 5
REG. NO. | | | | |
| 1. DECEASED NAME (TYPE OR PRINT)
ALBERT J. COONEY | | | | | 2a. DATE OF DEATH MONTH DAY YEAR
2/21/82 | | | 2b. HOUR
M | |
| 3 SEX
Male | | 4 RACE
Cauc. | | 5 DATE OF BIRTH MONTH DAY YEAR
6/26/06 | | 6 AGE (IN YEARS LAST BIRTHDAY)
75 YRS | | IF UNDER 1 YEAR MONTHS DAYS
IF UNDER 24 HRS HOURS MIN. | |
| 7a BIRTHPLACE (STATE OR FOREIGN COUNTRY)
Md. | | 7b CITIZEN OF WHAT COUNTRY?
U.S. | | 8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9 BALTIMORE CITY OR COUNTY OF DEATH
Balto. City MD. | | | |
| 10 CITY OR TOWN OF DEATH
Balto. | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
3722 Chestnut Ave. | | | | 12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)
Retired | | 12b KIND OF BUSINESS OR INDUSTRY
---- | |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) | | | | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | | |
| 13a. STATE
Md. | | 13b. COUNTY
---- | | 13c. CITY OR TOWN
Balto. | | 13e. STREET ADDRESS
3722 Chestnut Ave. | | | |
| 14 FATHER'S NAME FIRST MIDDLE LAST
✓ ? | | | | | 15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST
✓ ? | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)
no | | | 16b. SOCIAL SECURITY NO.
215-05-6802 | | 17. INFORMANT ADDRESS
Wife | | | | |
| 18 CAUSE OF DEATH (Enter only one cause per line, (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>Acute Congestive Heart Failure</u>
3989
DUE TO, OR AS A CONSEQUENCE OF (b) <u>Rheumatic Heart Disease</u>
DUE TO, OR AS A CONSEQUENCE OF (c) <u>w/ Abtrial Fibrillation</u>
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. | | | | | | | | | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a): | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR
9 P.M. 2 21 82 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | | | |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)
Home | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | | | |
| 22a. I certify that (1) (this hospital) attended the deceased from 2/14/82, 1982, to 2/21/82, 1982, that (1) (we) last saw the deceased alive on 2/11/82, 1982, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (If we) (did) (did not) view the body after death. | | | | | | | | | |
| 22b. SIGNATURE
<i>Diadema Simon-Beltran</i> | | | | | DEGREE
ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | | 22c. DATE SIGNED
2/22/82 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
DIADEMA SIMON-BELTRAN | | | | | 22e. ADDRESS
805 W. 36th St. Balto, Md 21211 | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)
Burial | | 23b. DATE
2/24/82 | | 23c. NAME OF CEMETERY OR CREMATORY
Lake View | | 23d. LOCATION CITY OR TOWN COUNTY STATE
Carroll Co. Md. | | | |
| 24 FUNERAL DIRECTOR NAME
Paul E. Chenoweth 3rd. 3617 Chestnut Ave. | | | | | 25a. DATE REC'D. BY REGISTRAR
FEB 25 1982 | | 25b. REGISTRAR'S SIGNATURE
<i>Thane J. [Signature]</i> | | |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed in the office after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be advised of this.

| STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH | | | | | | | | | | 8 2 0 3 6 4 6 | | | | | |
|--|--|--|---|--|--|---|--|--|---|--|---|--|--|----------------------------|--|
| 1. FOR STATE REGISTRAR | | | | | | | | | | REG. NO. | | | | | |
| 1. DECEASED NAME
(TYPE OR PRINT) Ethel P. Cooper | | | | | | | | | | 2a. DATE OF DEATH
MONTH DAY YEAR
February 7, 1982 | | | | 2b. HOUR
8:20A M | |
| 3. SEX
Female | | | 4. RACE
Black | | 5. DATE OF BIRTH
MONTH DAY YEAR
1 22 20 | | | 6. AGE (IN YEARS LAST BIRTHDAY)
YRS MONTHS DAYS
62 | | | IF UNDER 1 YEAR
HOURS MIN.
0 0 | | IF UNDER 24 HRS.
HOURS MIN.
0 0 | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
MD | | | 7b. CITIZEN OF WHAT COUNTRY?
USA | | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | | 9. BALTIMORE CITY OR COUNTY OF DEATH
Baltimore City MD. | | | | | | |
| 10. CITY OR TOWN OF DEATH
Baltimore | | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
Maryland General Hospital | | | | | | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
446 Walton Court | | | 12b. KIND OF BUSINESS OR INDUSTRY | | |
| 13a. STATE
MD | | | 13b. COUNTY | | 13c. CITY OR TOWN
Baltimore | | | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS
446 Walton Court | | | | | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
James E. Short | | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
Pauline Bundy | | | | | | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
No | | | 16b. SOCIAL SECURITY NO.
(IF YES, GIVE WAR OR DATES)
N/A | | 17. INFORMANT ADDRESS
Lorraine L. Johnson 3929 Ednor Rd. | | | | | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART 1. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Aspiration of Blood
1509
DUE TO, OR AS A CONSEQUENCE OF
(b) Hematochezia
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO, OR AS A CONSEQUENCE OF
(c) Esophageal Carcinoma | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
2 Hours
72 Hours
4 Months | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a
Sepsis | | | | | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | | | | | | | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK AT WORK | | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | | | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from February 4, 1982 , to February 7, 1982 , that (X) (we) lost
saw the deceased alive on February 7, 1982 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated
above. (I) (we) did (not) view the body after death. | | | | | | | | | | | | | | | |
| 22b. SIGNATURE
J. Rutkowski, M.D. | | | | | | | | DEGREE
ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> | | 22c. DATE SIGNED
2/7/82 | | | | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
Janice Rutkowski, M.D. | | | | | | | | 22e. ADDRESS
c/o Maryland General Hospital | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)
Burial | | | 23b. DATE
2/13/82 | | 23c. NAME OF CEMETERY OR CREMATORY
Mt. Auburn Cem. | | | 23d. LOCATION
CITY OR TOWN COUNTY MEDICAL
Baltimore | | | | | | | |
| 24. FUNERAL DIRECTOR
NAME ADDRESS
Wm. C. March F/H 1101 E. North Ave. | | | | | | | | 25a. DATE REC'D. BY REGISTRAR
FEB 9 1982 | | | | | | | |

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TO HOSPITAL OR ATTENDING PHYSICIAN. The law requires that the death certificate be executed within 24 hours after death. Page 4 must be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

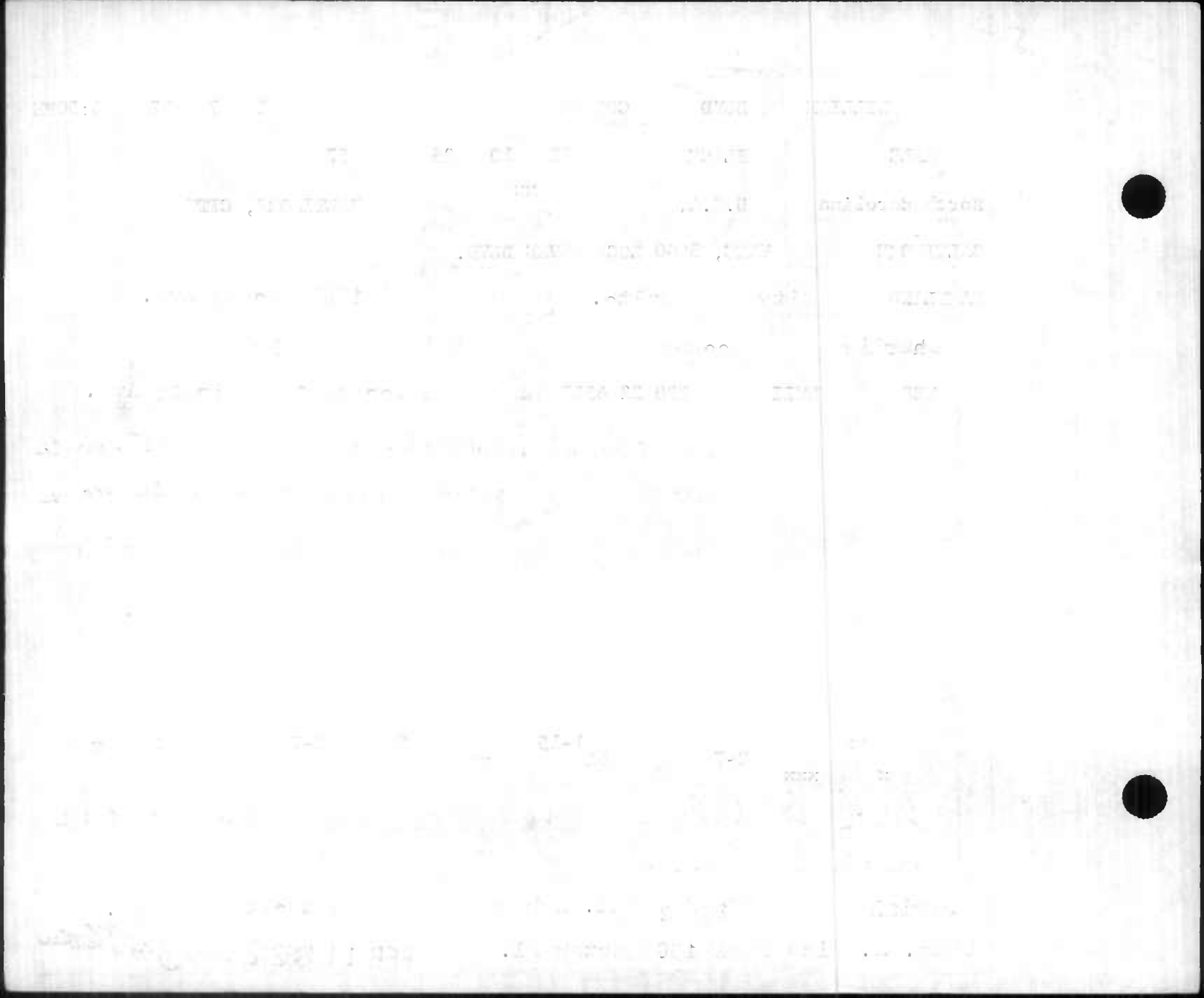
IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

FOR
1 - STATE
REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | |
|--|-------------------------|---|---|---|---------------------------|
| 1. DECEASED NAME
(TYPE OR PRINT) WILLIAM BOYD COOPER | | | 2a. DATE OF DEATH
MONTH 2 DAY 7 YEAR 82 | | 2b. HOUR
4:30PM |
| 3. SEX
MALE | 4. RACE
BLACK | 5. DATE OF BIRTH
12TH 10^{AY} 25^{EAR} | | 6. AGE (IN YEARS LAST BIRTHDAY)
57 | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
North Carolina | | 7b. CITIZEN OF WHAT COUNTRY?
U.S.A. | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | |
| 9. BALTIMORE CITY OR COUNTY OF DEATH
BALTIMORE, CITY | | MD | | | |
| 10. CITY OR TOWN OF DEATH
BALTIMORE | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
VAMC, 3900 LOCH RAVEN BLVD. | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE) | |
| 12b. KIND OF BUSINESS OR INDUSTRY | | | | | |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)
MARYLAND | | 13b. COUNTY
City | 13c. CITY OR TOWN
Balto. | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 14. FATHER'S NAME
FIRST Charlie MIDDLE Cooper LAST | | 15. MOTHER'S MAIDEN NAME
FIRST Mamie MIDDLE Ryans LAST | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
YES | | 16b. SOCIAL SECURITY NO.
230 22 6337 | | 17. INFORMANT
ADDRESS
Emma Mae Cooper 1703 Thomas Ave. | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART 1. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) arterial hemorrhage
1619
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last:
(b) extensive unresectable cancer of larynx
DUE TO, OR AS A CONSEQUENCE OF
(c) 20 years
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
= 5 minutes | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a: | | | | | |
| 19a. DATE OF OPERATION
2-7 | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER NOTIFY MEDICAL EXAMINER) | | | |
| 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | |
| 22a. I certify that the (this hospital) attended the deceased from 1-15 , 19 82 , to 2-7 , 19 82 , that he (we) last saw the deceased alive on 2-7 , 19 82 , and that in my (our) opinion death occurred on the date and hour and from the causes stated above. I (we) (did) not view the body after death. | | | | | |
| 22b. SIGNATURE
Kerth D. Osborn | | DEGREE
MD | | 22c. DATE SIGNED
2/8/82 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
Kerth D. Osborn | | 22e. ADDRESS
3900 LOCH RAVEN BLVD. BALTO. MD 21218 | | | |
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)
Burial | | 23b. DATE
2/13/82 | | 23c. NAME OF CEMETERY OR CREMATORY
Mt. Auburn | |
| 23d. LOCATION
CITY OR TOWN
Westport | | COUNTY
Md. | | STATE | |
| 24. FUNERAL DIRECTOR
NAME
Chas. A. Rice FSPA 1300 Eutaw Pl. | | 25a. DATE REC'D. BY REGISTRAR
FEB 11 1982 | | 25b. REGISTRAR'S SIGNATURE
Charles Santhorne | |



TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 must be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH | | | | | | | | | | 8 2 0 3 6 4 8 | | | | | | | |
|---|--|---|--|---|--|---|--|---|--|--|--|-----|--|------|--|---------|--|
| 1- FOR STATE REGISTRAR | | REG. NO. | | | | | | | | | | | | | | | |
| 1 DECEASED NAME (TYPE OR PRINT) | | FIRST | | MIDDLE | | LAST | | 2a DATE OF DEATH | | MONTH | | DAY | | YEAR | | 2b HOUR | |
| BERTIE | | Lou | | CORBIN | | | | 2-11-82 | | 3 38 | | | | | | A.M. | |
| 3 SEX | | 4 RACE | | 5 DATE OF BIRTH | | 6 AGE (IN YEARS LAST BIRTHDAY) | | IF UNDER 1 YEAR | | IF UNDER 24 HRS. | | | | | | | |
| FEMALE | | Caucas | | 9-29-28 | | 53 | | | | | | | | | | | |
| 7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) | | 8 CITIZEN OF WHAT COUNTRY? | | 9 BALTIMORE CITY OR COUNTY OF DEATH | | | | | | | | | | | | | |
| Baltimore Md | | USA | | BALT. CITY | | | | | | | | | | | | | |
| 10 CITY OR TOWN OF DEATH | | 11 NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) | | 12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | | 12b KIND OF BUSINESS OR INDUSTRY | | | | | | | | | | | |
| Baltimore Md | | WV. OF MARYLAND Hosp. | | Institutionalized | | | | | | | | | | | | | |
| 13a USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) | | 13b STATE | | 13c COUNTY | | 13d CITY OR TOWN | | 13e INSIDE CITY LIMITS? | | 13f STREET ADDRESS | | | | | | | |
| Md. | | 11 | | Anne Arundel | | Sykesville | | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | Spangfield Hosp. | | | | | | | |
| 14 FATHER'S NAME (FIRST, MIDDLE, LAST) | | 15 MOTHER'S MAIDEN NAME (FIRST, MIDDLE, LAST) | | 16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) | | 16b SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) | | 17 INFORMANT | | ADDRESS | | | | | | | |
| Herman H. Weibe | | Edna Grace Basler | | NO | | 2-26-1973 | | WV. MD. Hosp. | | | | | | | | | |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1: DEATH WAS CAUSED BY: | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | | | | | | |
| IMMEDIATE CAUSE (a) Pseudomonas Septis | | | | | | | | | | 5 Days | | | | | | | |
| 2041 DUE TO, OR AS A CONSEQUENCE OF (b) Pneumonia | | | | | | | | | | 2 wks | | | | | | | |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. DUE TO, OR AS A CONSEQUENCE OF (c) Chronic Lymphocytic Leukemia | | | | | | | | | | | | | | | | | |
| PART 2: OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) Granulocytopenia, Thrombocytopenia. | | | | | | | | | | | | | | | | | |
| 19a DATE OF OPERATION | | 19b CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a AUTOPSY? | | 20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? | | | | | | | | | | | |
| | | | | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | YES <input type="checkbox"/> NO <input type="checkbox"/> | | | | | | | | | | | |
| 21a ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR | | 21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | | | | | | | | | | | |
| | | P.M. 19 | | | | | | | | | | | | | | | |
| 21d INJURY OCCURRED AT HOME <input type="checkbox"/> AT WORK <input type="checkbox"/> | | 21e PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f LOCATION (STREET, CITY OR TOWN, COUNTY, STATE) | | | | | | | | | | | | | |
| | | | | | | | | | | | | | | | | | |
| 22a I certify that (1) this hospital attended the deceased from FEB 5 19 82, to FEB 11 19 82, the (11) last saw the deceased alive on FEB 11 19 82, and that in my (100) opinion death occurred on the date and hour and from the causes stated | | | | | | | | | | | | | | | | | |
| 22b SIGNATURE | | DEGREE | | 22c DATE SIGNED | | | | | | | | | | | | | |
| Stephen Puentes M.D. | | M.D. | | 2/11/82 | | | | | | | | | | | | | |
| 22d PHYSICIAN'S NAME (TYPE OR PRINT) | | 22e ADDRESS | | | | | | | | | | | | | | | |
| Stephen Puentes M.D. | | WV. OF MARYLAND Hosp. | | | | | | | | | | | | | | | |
| 23a BURIAL, CREMATION, REMOVAL (SPECIFY) | | 23b DATE | | 23c NAME OF CEMETERY OR CREMATORY | | 23d LOCATION (CITY OR TOWN, COUNTY, STATE) | | | | | | | | | | | |
| Burial | | 2-13-82 | | Leister's Cemetery | | Westminster, Carroll Md. | | | | | | | | | | | |
| 24 FUNERAL DIRECTOR NAME | | ADDRESS | | 25a RECEIVED BY REGISTRAR | | 25b DATE | | | | | | | | | | | |
| Eline Funeral Home, Hampstead, Md. 21074 | | | | | | FEB 16 1982 | | | | | | | | | | | |

BP

- 13 -

8 2 0 3 6 4 9

1 - FOR
STATE
REGISTRAR

REG. NO.

| | | | | | | | | | | | | | |
|---|--|---|--|--|-------------|--|--|--|----------------------|---|--|--|--|
| 1 DECEASED NAME
(TYPE OR PRINT) | | FIRST
MATTIE | | MIDDLE
B | LAST
COX | | 2a DATE OF DEATH
MONTH DAY YEAR
02 03 82 | | 2b HOUR
5:15 A.M. | | | | |
| 3 SEX
Female | | 4 RACE
Black | | 5 DATE OF BIRTH
MONTH DAY YEAR
08 29 09 | | 6 AGE (IN YEARS LAST BIRTHDAY)
72 YRS. | | IF UNDER 1 YEAR
MONTHS DAYS | | IF UNDER 24 HRS.
HOURS MIN. | | | |
| 7a BIRTHPLACE
(STATE OR FOREIGN COUNTRY)
Virginia | | 7b CITIZEN OF WHAT COUNTRY?
U.S.A. | | 8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9 BALTIMORE CITY OR COUNTY OF DEATH
Baltimore City, Md | | | | | | | |
| 10 CITY OR TOWN OF DEATH
Baltimore City | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
Mercy Hospital, 301 St. Paul Place | | | | 12a USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
Homemaker | | 12b. KIND OF BUSINESS OR INDUSTRY
Home. | | | | | |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)
13a. STATE
Maryland | | | | | | 13b. COUNTY
- | | 13c. CITY OR TOWN
Baltimore City | | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS
124 W. Franklin St., Apt. 706 | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
Emmett Gresham | | | | | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
Bessie Muse | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
NO | | | | 16b. SOCIAL SECURITY NO.
* | | 17. INFORMANT
ADDRESS
Augusta Murray 3201 Leighton Ave. | | | | | | | |
| 18. CAUSE OF DEATH: Enter only one cause per line for (a), (b), and (c).
PART I: DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Cardiac Arrest
4275
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last
(b) Cardiac Arrest and Pulmonary Edema
(c)
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
16 Days | | | | | | | | | | | | | |
| PART 2: OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a | | | | | | | | | | | | | |
| MEDICAL CERTIFICATION | | | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | | | | | | | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK AT WORK | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | | | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from January 19, 1982, to February 3, 1982, that (I) (we) last saw the deceased alive on February 3, 1982, and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) did not view the body after death. | | | | | | | | | | | | | |
| 22b. SIGNATURE
Neal M. Friedlander, MD | | | | | | DEGREE
ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> | | 22c. DATE SIGNED
Feb 3, 1982 | | | | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
Neal M. Friedlander | | | | | | 22e. ADDRESS
Mercy Hospital, 301 St Paul Place, Baltimore, Md 2120 | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)
BURIAL | | 23b. DATE
2-6-82 | | 23c. NAME OF CEMETERY OR CREMATORY
WESTERN STAR | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
BALTO Md. | | | | | | | |
| 24. FUNERAL DIRECTOR
NAME ADDRESS
Jas A. Morton & Sons 1701 Laurens | | | | | | 25a. DATE REC'D BY REGISTRAR
FEB 4 1982 | | 25b. REGISTRAR'S SIGNATURE
Anne J. Smith | | | | | |

TO HOSPITAL OR ATTENDING PHYSICIAN. The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, it must be placed in the body of the casket. Pages 1 and 2 must be removed within 72 hours after death and must be detached for use as the burial-transit permit. Please remove carbon papers. Pages 3 and 4 must be retained by the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION



STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 2 0 3 6 5 0

1- FOR
STATE
REGISTRAR

REG. NO.

| | | | | | |
|--|--|---|---|--|---|
| 1. DECEASED NAME
(TYPE OR PRINT)
THOMAS H. CREASMAN THOMAS H. CREASMAN | | | 2a. DATE OF DEATH
MONTH DAY YEAR
2 13 82 | | 2b. HOUR
12 05 A.M. |
| 3. SEX
MALE | 4. RACE
CAUC.
WHITE | 5. DATE OF BIRTH
MONTH DAY YEAR
4 8 02 | | 6. AGE (IN YEARS LAST BIRTHDAY)
79 YRS. | IF UNDER 1 YEAR
MONTHS DAYS HOURS MIN. |
| 7a. BIRTHPLACE
(STATE OR FOREIGN COUNTRY)
North Carolina | 7b. CITIZEN OF WHAT COUNTRY?
U.S.A. | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
BALTIMORE CITY MD. | |
| 10. CITY OR TOWN OF DEATH
Baltimore | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
MERCY HOSPITAL | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
Electrician | | 12b. KIND OF BUSINESS OR INDUSTRY |
| 13a. STATE
Md. | 13b. COUNTY | 13c. CITY OR TOWN
Baltimore | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | 13e. STREET ADDRESS
619 N. Decker Ave. | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
Robert Creasman | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
Elizabeth Jones | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
No | | 16b. SOCIAL SECURITY NO.
237-18-7984 | | 17. INFORMANT
ADDRESS
Patricia Trainor 619 N. Decker Ave. | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART 1. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) 4100 Acute myocardial infarction
DUE TO, OR AS A CONSEQUENCE OF
(b) Acute adult respiratory distress syndrome
DUE TO, OR AS A CONSEQUENCE OF
(c) Hypertension during cardiac arrest
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a): | | | | | APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATH |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input type="checkbox"/> | 20b. IF YES, WERE FINDINGS USED
IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | |
| 21d. INJURY OCCURRED
WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | |
| 22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) last saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (If (we) (did) (did not) view the body after death.) | | | | | |
| 22b. SIGNATURE
Stephen D. Campbell, MD | | DEGREE
MD | | 22c. DATE SIGNED
2/13/82 | |
| 22e. PHYSICIAN'S NAME (TYPE OR PRINT)
Stephen D. Campbell, MD | | 22f. ADDRESS
Mercy Hospital, Balto, MD | | | |
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)
Burial | 23b. DATE
2/18/82 | 23c. NAME OF CEMETERY OR CREMATORY
Greenhills Cem. | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
Asheville North Carolina | |
| 24. FUNERAL DIRECTOR
NAME
B. Dabrowski & Son | | ADDRESS
2818 E. Baltimore St. | | 25a. DATE REC'D. BY REGISTRAR
FEB 18 1982 | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH | | | | | | | | | | REG. NO. 8 2 0 3 5 1 | |
|---|--|---|--|---|---|--|--|---|--|----------------------|--|
| 1. DECEASED NAME (TYPE OR PRINT)
FIRST MIDDLE LAST
<i>Mansuet Crayke</i> | | | | | 2a. DATE OF DEATH
MONTH DAY YEAR
<i>2 19 82</i> | | | 2b. HOUR
<i>6:22 a.m.</i> | | | |
| 3. SEX
<i>FEMALE</i> | | 4. RACE
<i>NEGRO</i> | | 5. DATE OF BIRTH
MONTH DAY YEAR
<i>12 14 18</i> | | 6. AGE (IN YEARS LAST BIRTHDAY)
<i>62</i> YRS | | 7. IF UNDER 1 YEAR
MONTHS DAYS
IF UNDER 24 HRS.
HOURS MIN. | | | |
| 8. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
<i>MARYLAND</i> | | 9. CITIZEN OF WHAT COUNTRY?
<i>U.S.A.</i> | | 10. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/> | | 11. BALTIMORE CITY OR COUNTY OF DEATH
<i>BALTIMORE CITY</i> MD. | | | | | |
| 12. CITY OR TOWN OF DEATH
<i>BALTIMORE</i> | | 13. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
<i>BALTIMORE CITY HOSP.</i> | | | | 14. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
<i>DOMESTIC</i> | | 15. KIND OF BUSINESS OR INDUSTRY | | | |
| 16. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)
16a. STATE
<i>MARYLAND</i> | | 16b. COUNTY
<i>BALTIMORE</i> | | 16c. CITY OR TOWN
<i>BALTIMORE</i> | | 16d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 16e. STREET ADDRESS
<i>1701 Eutan Place apt. 926</i> | | | |
| 17. FATHER'S NAME
FIRST MIDDLE LAST
<i>OSCAR CROSWELL</i> | | 18. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
<i>HATTIE KIRK</i> | | 19. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)
<i>NO</i> | | 20. SOCIAL SECURITY NO.
<i>220-12-6464</i> | | 21. INFORMANT
<i>AUDREY ANTHONY</i> | | | |
| 22. ADDRESS
<i>1701 Eutan Place</i> | | 23. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART 1. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <i>Cardiopulmonary arrest</i>
<i>4275</i>
DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b) _____
DUE TO, OR AS A CONSEQUENCE OF
(c) _____ | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:
<i>Chronic Renal Failure</i> | | | | | | | | | | | |
| 24. DATE OF OPERATION
<i>2/19</i> | | 25. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 26. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 27. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | |
| 28. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 29. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
<i>P.M. 19</i> | | 30. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | | | | | |
| 31. INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/> | | 32. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 33. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | | | | | |
| 34. I certify that (I) (this hospital) attended the deceased from <i>2/18</i> , 19 <i>81</i> , to <i>2/19</i> , 19 <i>82</i> , that (I) (we) lost
saw the deceased alive on <i>2/19</i> , 19 <i>81</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated
above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | | | |
| 35. SIGNATURE
<i>Bram Zucker</i> | | 36. DEGREE
<i>MD</i> | | 37. ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | 38. DATE SIGNED
<i>2/19/82</i> | | | | | |
| 39. PHYSICIAN'S NAME (TYPE OR PRINT)
<i>Bram Zucker</i> | | 40. ADDRESS
<i>Baltimore City Hosp</i> | | | | | | | | | |
| 41. BURIAL, CREMATION, REMOVAL (SPECIFY)
<i>BURIAL</i> | | 42. DATE
<i>2/24/82</i> | | 43. NAME OF CEMETERY OR CREMATORY
<i>MT. AUBURN Cem.</i> | | 44. LOCATION
CITY OR TOWN COUNTY STATE
<i>BALTIMORE Md.</i> | | | | | |
| 45. FUNERAL DIRECTOR
<i>CHAS. H. POWELL</i> | | 46. ADDRESS
<i>F/H 319 N. Schroeder</i> | | 47. DATE REC'D BY REGISTRAR
<i>FEB 23 1982</i> | | 48. REGISTRAR'S SIGNATURE
<i>Thomas J. ...</i> | | | | | |

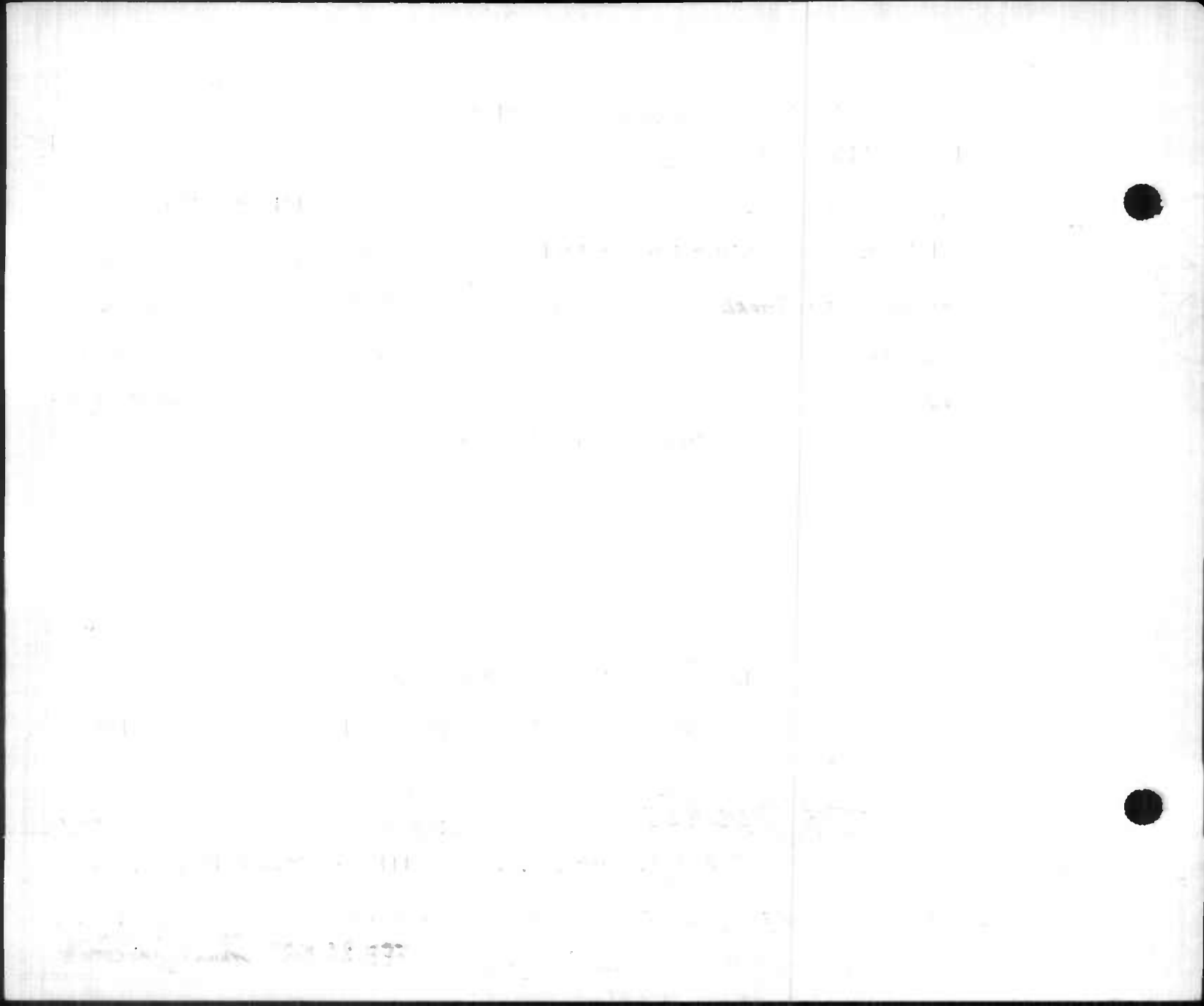
1401 BP

FEB 5 1965

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR VITAL FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITH IN 24 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

| STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH | | | | | | | | | | REG. NO. 5 2 0 3 6 5 2 | |
|--|--|------------------|--|---|--|---|--|---|--|---|--|
| 1. DECEASED NAME
(TYPE OR PRINT) FIRST MIDDLE LAST
Scott CHARLES Crist | | | | | | 2a. DATE KNOWN OF DEATH
ESTIMATED MONTH DAY YEAR
2 22 1982 | | 2b. HOUR
M | | | |
| 3. SEX
Male | | 4. RACE
White | | 5. DATE OF BIRTH
MONTH DAY YEAR
9 28 59 | | 6. AGE (IN YEARS)
(LAST BIRTHDAY) MONTHS DAYS HOURS MIN
22 YRS. | | 7c. DATE PRONOUNCED DEAD
MONTH DAY YEAR
2 22 1982 | | 7d. HOUR
1:34 a m | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
PENNSYLVANIA | | | | 7b. CITIZEN OF WHAT COUNTRY?
USA | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
Baltimore City, MD. | | | |
| 10. CITY OR TOWN OF DEATH
Baltimore | | | | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
University Hospital | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)
INDUSTRIAL ENGINEER | | 12b. KIND OF BUSINESS OR INDUSTRY
BENDIX | |
| 13a. USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION):
13a. STATE MARYLAND 13b. COUNTY BALTIMORE 13c. CITY OR TOWN COCKEYSVILLE 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> 13e. STREET ADDRESS 118 HOGARTH CIRCLE | | | | | | | | | | | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
MELLARD CRIST | | | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
CATHERINE HAUG | | | | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) NO 16b. SOCIAL SECURITY NO. 180-44-3878 17. INFORMANT MISS WENDY LOU BAKER ADDRESS WILLIAMSPORT, PA. | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I DEATH WAS CAUSED BY:
9654 IMMEDIATE CAUSE (a) Gunshot wound to chest
Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last:
(b) DUE TO, OR AS A CONSEQUENCE OF
(c) DUE TO, OR AS A CONSEQUENCE OF
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a. | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| MEDICAL CERTIFICATION | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | | | | 20. AUTOPSY?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH | | | | 21b. TIME OF INJURY
HOUR MIN MONTH DAY YEAR
10 P.M. 2 21 1982 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)
Subject shot | | | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK | | | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)
street | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE
12 Hogarth Circle Balto., Md. | | | | | |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input checked="" type="checkbox"/> , Undetermined manner <input type="checkbox"/> . | | | | | | | | | | | |
| ACTUAL SIGNATURE
Hormez R. Guard | | | | TITLE (SPECIFY)
M.D. Assistant | | | | DATE SIGNED
2/22/82 | | | |
| EXAMINER'S NAME (TYPE OR PRINT)
Hormez R. Guard, M.D. | | | | ADDRESS
111 Penn St. Balto., Md. | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)
CREMATION | | | | 23b. DATE
2/23/82 | | 23c. NAME OF CEMETERY OR CREMATORY
SECURITY PROCESSING, INC. | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
CATONSVILLE BALTIMORE MD | | | |
| 24. FUNERAL DIRECTOR
NAME
MARZULLO FUNERAL SERVICE | | | | ADDRESS
REISTERSTOWN, MD. | | | | 25a. DATE REC'D. BY REGISTRAR
FEB 23 1982 | | 25b. REGISTRAR'S SIGNATURE
Thom J. Gantner | |

0000 BP



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

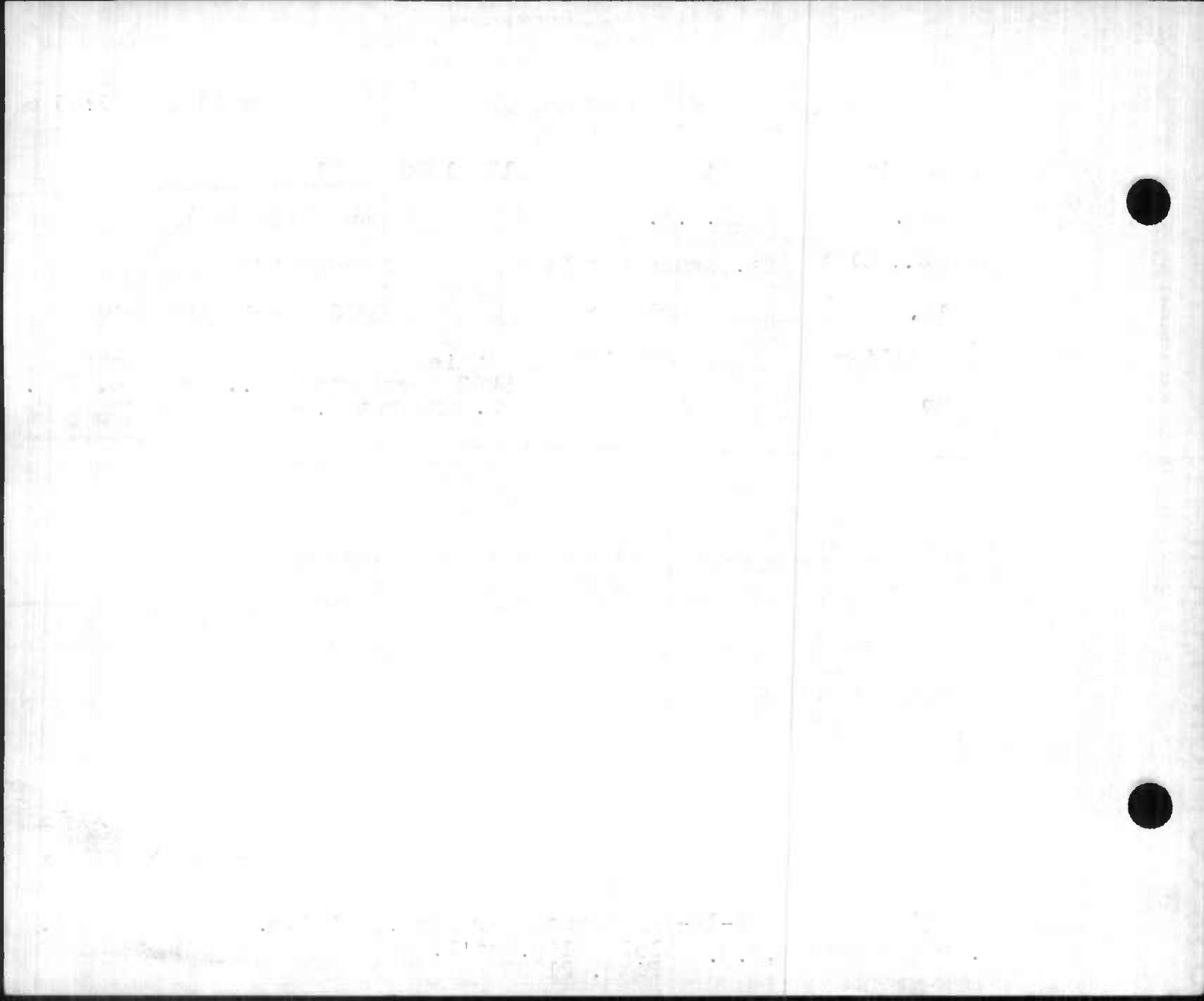
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the registrar, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified by the registrar.

BP

DHMH-16 50M 1/81
(VRA 15, 4)

| STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH | | | | | | | | | |
|--|--|--|--|--|--|---|--|--|--|
| 1. FOR STATE REGISTRAR | | 2a. DATE OF DEATH | | | | | | 2b. HOUR | |
| 1. DECEASED NAME (TYPE OR PRINT) | | 2a. DATE OF DEATH | | | | | | 2b. HOUR | |
| MARGARET V CRUMBACKER | | 02 12 82 | | | | | | 7:45 a M | |
| 3. SEX | | 4. RACE | | 5. DATE OF BIRTH | | 6. AGE (IN YEARS LAST BIRTHDAY) | | 7. IF UNDER 1 YEAR | |
| Female | | White | | 3 10 1890 | | 97 YRS. | | MONTHS DAYS HOURS MIN. | |
| 7a. BIRTHPLACE (COUNTRY) | | 7b. CITIZEN OF WHAT COUNTRY? | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH | | | |
| Md. | | U.S.A. | | | | BALTIMORE CITY MD. | | | |
| 10. CITY OR TOWN OF DEATH | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | | 12b. KIND OF BUSINESS OR INDUSTRY | |
| BALTO., CITY | | St. Agnes Hospital | | | | Housewife | | | |
| 13a. STATE | | 13b. COUNTY | | 13c. CITY OR TOWN | | 13d. INSIDE CITY LIMITS? | | 13e. STREET ADDRESS | |
| Fla. | | Orlando | | YES <input type="checkbox"/> NO <input type="checkbox"/> | | 5862 Harrington Drive | | 32808 | |
| 14. FATHER'S NAME | | 15. MOTHER'S MAIDEN NAME | | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) | | | | | |
| William Jenkins | | Annie Simmons | | no | | | | | |
| 16b. SOCIAL SECURITY NO. | | 17. INFORMANT | | 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: | | | | | |
| 215-12-1372 | | Mrs. Margaret V. Fear | | IMMEDIATE CAUSE (a) 4100 CARDIAC ARREST | | | | | |
| | | | | DUE TO, OR AS A CONSEQUENCE OF (b) ACUTE MYOCARDIAL INFARCTION | | | | | |
| | | | | DUE TO, OR AS A CONSEQUENCE OF (c) | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a. RENAL FAILURE, CONGESTIVE HEART FAILURE, SIP CHOLECTECTOMY | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY? | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? | |
| | | | | | | YES <input type="checkbox"/> NO <input type="checkbox"/> | | YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | | | |
| | | HOUR A.M. MONTH DAY YEAR | | | | | | | |
| 21d. INJURY OCCURRED | | 21e. PLACE OF INJURY (AT HOME STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION | | | | | |
| WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | | | STREET CITY OR TOWN COUNTY STATE | | | | | |
| 22a. I certify that (he/she) attended the deceased from 12 27 81, 19 81, to 2 18, 19 82, that (he/we) lost saw the deceased alive on 2 12, 19 82, and that in (my/our) opinion death occurred on the date and hour and from the causes stated above, (I/we) (did) (did not) view the body after death. | | | | | | | | | |
| 22b. SIGNATURE | | 22c. DATE SIGNED | | | | | | | |
| Geetha Raja MD | | 2-12-82 | | | | | | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) | | 22e. ADDRESS | | 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) | | | | | |
| GEETHA RAJA MD | | ST. AGNES HOSPITAL, BALTIMORE MD 21228 | | Burial | | | | | |
| 23b. DATE | | 23c. NAME OF CEMETERY OR CREMATORY | | 23d. LOCATION | | 23e. DATE REC'D. BY REGISTRAR | | | |
| 2-16-82 | | Loudon Park Cem. | | Balto. | | FEB 19 1982 | | | |
| 23f. FUNERAL DIRECTOR | | 23g. DATE REC'D. BY REGISTRAR | | 23h. REGISTRAR'S SIGNATURE | | 23i. REGISTRAR'S SIGNATURE | | | |
| G. Truman Schwab, P.A. | | 5151 Balto. Nat'l Pike, 21229 | | FEB 19 1982 | | | | | |



TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

| STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH | | | | | | | | | | REG. NO.
8 2 0 3 5 4 | |
|---|--|---|--|---|--|--|--|---|--|-------------------------|--|
| 1. DECEASED NAME
(TYPE OR PRINT) Wayne Richard Crunkleton | | | | | | 2a. DATE OF DEATH
MONTH DAY YEAR
2 / 16 / 82 | | 2b. HOUR
6:05 A.M. | | | |
| 3. SEX
Male | | 4. RACE
White | | 5. DATE OF BIRTH
MONTH DAY YEAR
10 25 22 | | 6. AGE (IN YEARS LAST BIRTHDAY)
59 YRS. | | IF UNDER 1 YEAR
MONTHS DAYS HOURS MIN. | | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
Pennsylvania | | 7b. CITIZEN OF WHAT COUNTRY?
USA | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
Baltimore City MD. | | | | | |
| 10. CITY OR TOWN OF DEATH
Baltimore | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
University Hospital | | | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
truck driver | | 12b. KIND OF BUSINESS OR INDUSTRY
Pot. Edison Co. | | | |
| 13a. STATE
Maryland | | 13b. COUNTY
Washington | | 13c. CITY OR TOWN
Hagerstown | | 13d. INSIDE CITY LIMITS?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 13e. STREET ADDRESS
157 Manse Road | | | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
J. F. Crunkleton | | | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
Bertha Tice | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
Yes | | 16b. SOCIAL SECURITY NO.
(IF YES, GIVE WAR OR DATES)
W.W. II | | 17. INFORMANT
ADDRESS
Betty J. Crunkleton, Hagerstown, Md. | | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART 1. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Septic Shock
2050
DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.
(b) Acute myelogenous Leukemia
DUE TO, OR AS A CONSEQUENCE OF
(c) | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a) | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) | | | | | | | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> AT WORK
AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 2/15/82 , 19____, to 2/16/82 , 19____, that (I) (we) last saw the deceased alive on 2/16/82 , 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | | | |
| 22b. SIGNATURE
Haleshi M. Patel | | | | DEGREE
M.D. | | ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> | | 22c. DATE SIGNED
2/16/82 | | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
HALESHT M. PATEL, MD. | | | | 22e. ADDRESS
UNIVERSITY OF MARYLAND HOSPITAL, BALTIMORE, MARYLAND | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)
burial | | 23b. DATE
Feb. 20, 1982 | | 23c. NAME OF CEMETERY OR CREMATORY
Rest Haven Cemetery | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
Hagerstown, Wash., Maryland | | | | | |
| 24. FUNERAL DIRECTOR
NAME ADDRESS
MINNICH FUNERAL HOME
415 E. Wilson Blvd., Hagerstown, Md. 21740 | | | | | | 25a. DATE REC'D. BY REGISTRAR
FEB 22 1982 | | 25b. REGISTRAR'S SIGNATURE
James J. Nathan | | | |

BP

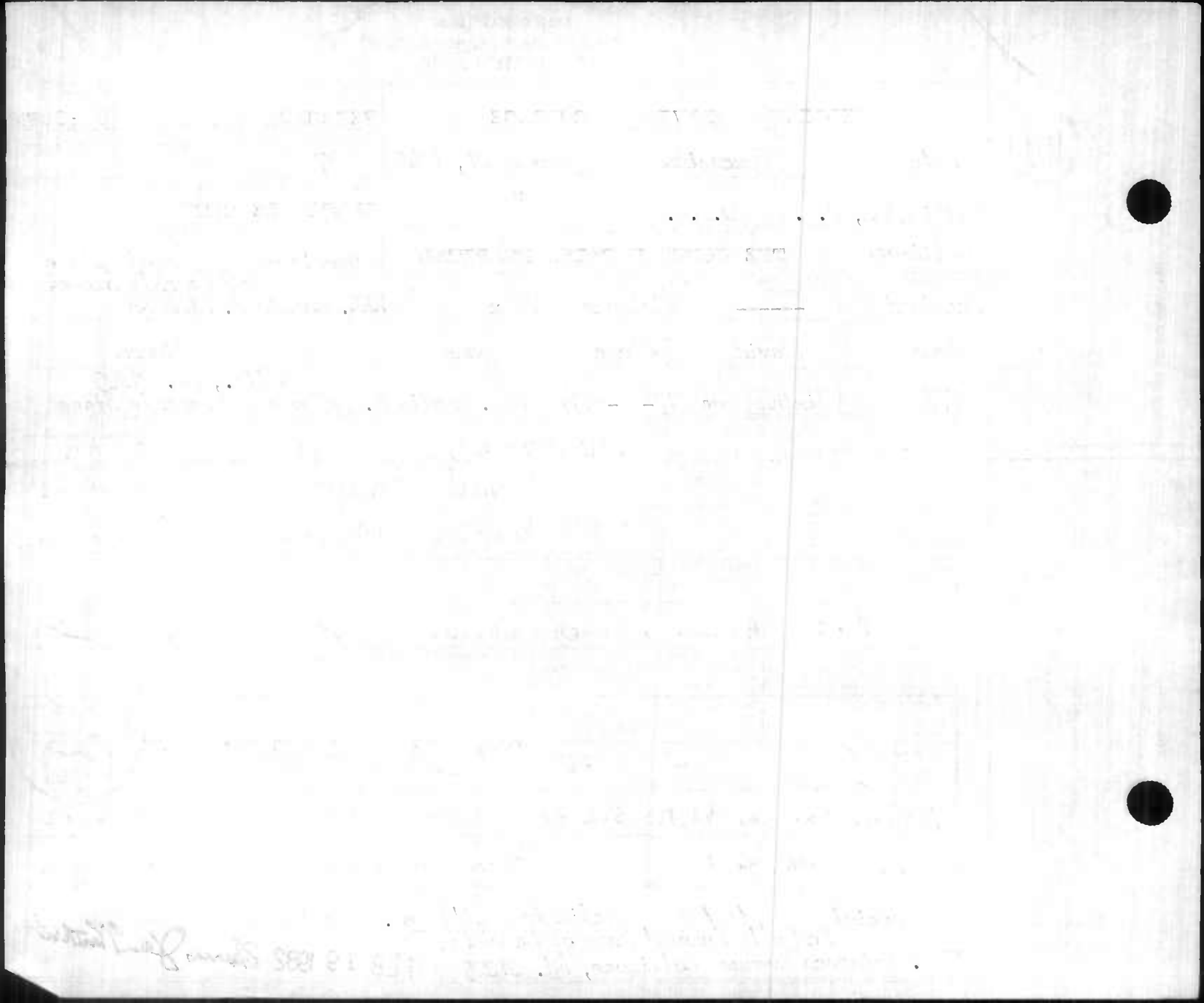
$$\int_0^1 \sqrt{1-x^2} dx = \frac{\pi}{4}$$

in the interval $[-1, 1]$

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled within 72 hours with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified and advised.

| STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH | | | | 8 2 0 3 6 5 5 | | | |
|--|--|---|--|---|--|---|--|
| FOR
1 - STATE
REGISTRAR | | | | REG. NO. | | | |
| 1. DECEASED NAME (TYPE OR PRINT)
FIRST MIDDLE LAST
WILLIAM DAVID CUBBAGE | | | | 2a. DATE OF DEATH
MONTH DAY YEAR
FEBRUARY 14, 1982 | | 2b. HOUR
08:30PM | |
| 3. SEX
Male | | 4. RACE
Caucasian | | 5. DATE OF BIRTH
MONTH DAY YEAR
January 21, 1945 | | 6. AGE (IN YEARS LAST BIRTHDAY)
37 YRS
IF UNDER 1 YEAR MONTHS DAYS HOURS MIN. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
Washington, D.C. | | 7b. CITIZEN OF WHAT COUNTRY?
U.S.A. | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
BALTIMORE CITY MD. | |
| 10. CITY OR TOWN OF DEATH
Baltimore | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
THE JOHNS HOPKINS HOSPITAL | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)
Developer | | 12b. KIND OF BUSINESS OR INDUSTRY
Real Estate | |
| 13a. STATE
Maryland | | 13b. COUNTY
--- | | 13c. CITY OR TOWN
Baltimore | | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
Henny David Cubbage | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
Jane Gallahan | | 16. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, GIVE WAR OR DATES)
YES Vietnam War | | 16b. SOCIAL SECURITY NO.
217-42-8434 | |
| 17. INFORMANT
Mrs. Amelia M. Cubbage | | 18. ADDRESS
Balto., Md. 21225 | | 19. ADDRESS
402 Frankle Street | | 20. ADDRESS
402 Frankle Street | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART 1. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) PNEUMONIA
5728
DUE TO, OR AS A CONSEQUENCE OF RENAL FAILURE
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.
(b) HEPATIC FAILURE
DUE TO, OR AS A CONSEQUENCE OF AT LEAST SIX MONTHS
(c) AT LEAST SIX MONTHS | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
2 DAYS
4 WEEKS
AT LEAST SIX MONTHS | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) | | | | | | | |
| 19a. DATE OF OPERATION
1.28.82 | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED
AV SHUNT FOR HAEMO DIALYSIS | | 20a. AUTOPSY?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | |
| 22a. I certify that (a) (this hospital) attended the deceased from 2.14.82 to 2.14.82 , that (b) (not) lost saw the deceased alive on 2.14.82 , and that in (my) low opinion death occurred on the date and hour and from the causes stated above, (b) (yes) (did) (did not) view the body after death. | | | | | | | |
| 22b. SIGNATURE
N. Parfrey | | | | DEGREE
BA, M.B., BCh, BAO. | | 22c. DATE SIGNED
2.14.82 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
N. PARFREY | | | | 22e. ADDRESS
JOHNS HOPKINS HOSPITAL, BALTIMORE. | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)
Burial | | 23b. DATE
2/18/82 | | 23c. NAME OF CEMETERY OR CREMATORY
Arlington Nat'l Cem. | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
Arlington Virginia | |
| 24. FUNERAL DIRECTOR
NAME ADDRESS
Mc Cully Funeral Home of Brooklyn | | | | 25a. DATE REC'D. BY REGISTRAR IN REGISTRAR'S OFFICE
FEB 19 1982 | | | |
| 27. ADDRESS
237 E. Patapsco Avenue Baltimore, Md. 21225 | | | | 28. SIGNATURE
James San Martin | | | |



TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH, IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP

DHM-17
(VR A15 ME (5))
15M 2/80

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

1- FOR
STATE
REGISTRAR

| | | | | | | | | |
|---|---------|--|-------------------------|---|---|---|---------------------|-----------------------------------|
| 1. DECEASED NAME
(TYPE OR PRINT) | | | 20. DATE KNOWN OF DEATH | | | 21. HOUR | | |
| Michael Elliott Cumbo | | | 2. 21 19 82 | | | M | | |
| 3. SEX | 4. RACE | 5. DATE OF BIRTH | 6. AGE (IN YEARS) | IF UNDER 1 YR. | IF UNDER 24 HRS. | 22. DATE PRONOUNCED DEAD | 23. HOUR | 24. HOUR |
| Male | Black | 3 17 60 | 21 YRS. | | | 2 21 19 82 | 7:46 P | M |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) | | 7b. CITIZEN OF WHAT COUNTRY? | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH | | |
| Balto., Md. | | USA | | WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | Baltimore City, MD. | | |
| 10. CITY OR TOWN OF DEATH | | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | | 12b. KIND OF BUSINESS OR INDUSTRY |
| Baltimore | | 2800 Blk. Indianhead Drive | | | | | | |
| 13a. USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) | | | | | | | | |
| 13b. STATE | | | 13c. COUNTY | | 13d. IN-CITY LIMITS? | | 13e. STREET ADDRESS | |
| Md. | | | Balto. | | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 5001 Midwood Ave. | |
| 14. FATHER'S NAME | | | | 15. MOTHER'S MAIDEN NAME | | | | |
| Gilbert Cumbo | | | | Ethel | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? | | | | 16b. SOCIAL SECURITY NO. | | 17. INFORMANT ADDRESS | | |
| No | | | | 240 25 9197 | | Gilbert Cumbo 6975 McClain Blvd. | | |

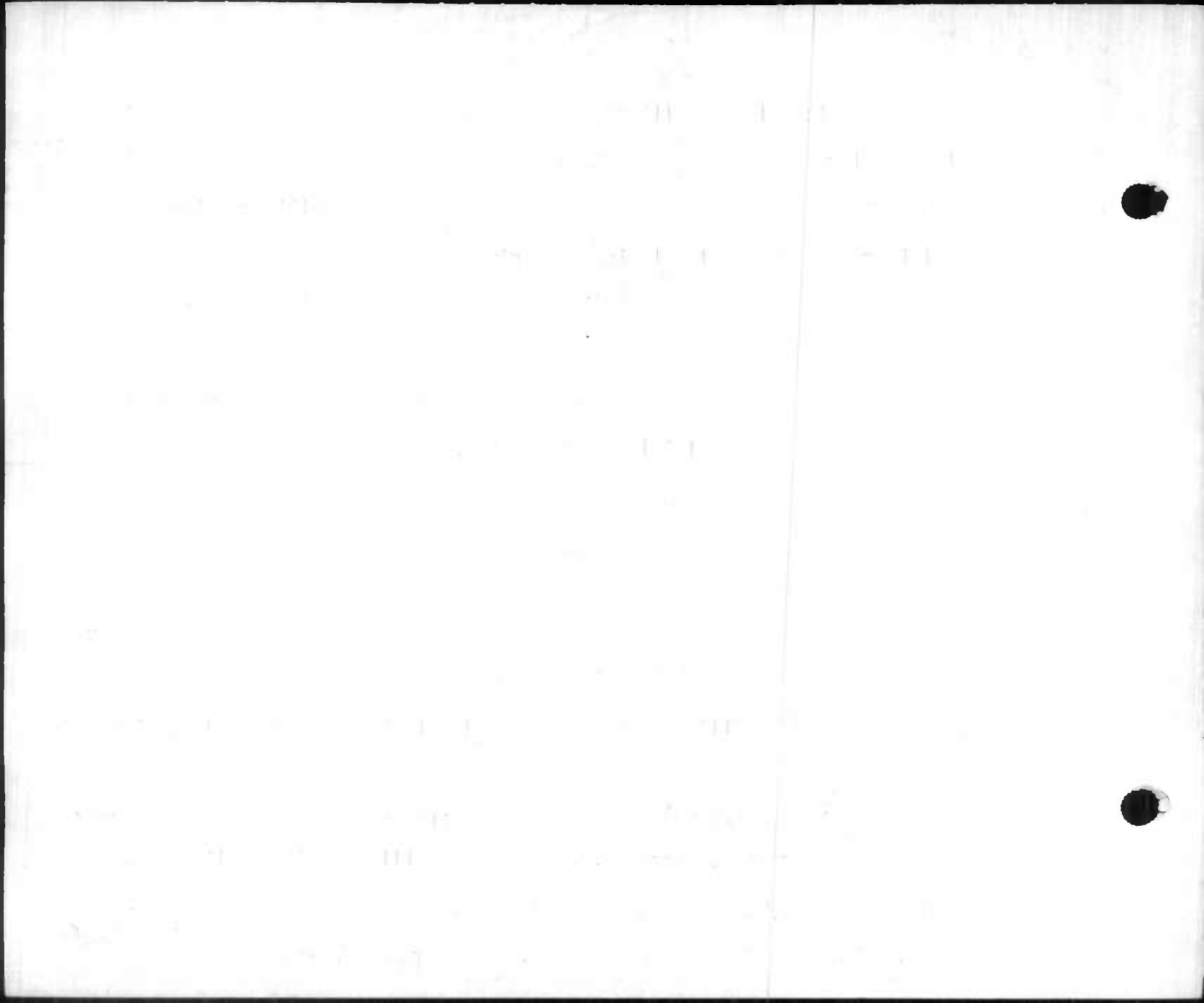
MEDICAL CERTIFICATION

| | | |
|---|--|--|
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART I DEATH WAS CAUSED BY: | | |
| IMMEDIATE CAUSE (a) Multiple gunshot wounds | | |
| DUE TO, OR AS A CONSEQUENCE OF | | |
| (b) | | |
| DUE TO, OR AS A CONSEQUENCE OF | | |
| (c) | | |

PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1

| | | | | | |
|--|--|---|--|---|--|
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | | 20. AUTOPSY? | |
| | | | | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH | | 21b. TIME OF INJURY | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) | |
| | | 7:40 M. 2 21 19 82 | | Subject shot | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) | | 21f. LOCATION | |
| | | Clifton Park | | 2800 Blk. Indianhead Dr., Balto. City, Md. | |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input checked="" type="checkbox"/> Undetermined manner <input type="checkbox"/> . | | | | | |
| ACTUAL SIGNATURE | | TITLE (SPECIFY) | | DATE SIGNED | |
| H. Shaid | | M.D. Assistant | | 2/22/82 | |
| EXAMINER'S NAME (TYPE OR PRINT) | | ADDRESS | | | |
| Hormez R. Guard, M.D. | | 111 Penn St. Balto., MD. | | | |

| | | | | | | | | | | | |
|---|--|-----------|--|------------------------------------|--|-------------------------------|--|-------------------------------|--|----------------------------|--|
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) | | 23b. DATE | | 23c. NAME OF CEMETERY OR CREMATORY | | 23d. LOCATION | | 23e. DATE REC'D. BY REGISTRAR | | 23f. REGISTRAR'S SIGNATURE | |
| Burial | | 3/ 1 /82 | | Cumbo Family Cem. | | Conway, North Carolina | | FEB 23 1982 | | Francis J. Nathan | |
| 24. FUNERAL DIRECTOR | | | | | | 25a. DATE REC'D. BY REGISTRAR | | | | | |
| LEROY O. DYETT 4600 LIBERTY HEIGHTS AVE. | | | | | | | | | | | |



TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 must be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 1 and 2 should be detached for use as the burial-transit permit. Then please remove carbon copies. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of once.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 2 0 3 6 5 7

| | | | |
|--|--|---|--|
| 1. FOR STATE REGISTRAR | | REG. NO. | |
| 1. DECEASED NAME
(TYPE OR PRINT) FIRST MIDDLE LAST
CHARLOTTE CUMMINGS | | 2a. DATE OF DEATH MONTH DAY YEAR
2 19 82 | |
| 3. SEX
Female | | 2b. HOUR
9:45 P.M. | |
| 4. RACE
W White | | 6. AGE (IN YEARS LAST BIRTHDAY)
81 | |
| 5. DATE OF BIRTH MONTH DAY YEAR
4 11 00 | | 7. IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.
IF UNDER 24 HRS. HOURS MIN. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
Maryland | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | |
| 7b. CITIZEN OF WHAT COUNTRY?
USA | | 9. BALTIMORE CITY OR COUNTY OF DEATH
BALTO. CITY MD. | |
| 10. CITY OR TOWN OF DEATH
BALTIMORE | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
LUTHERAN | |
| 12a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)
13a. STATE
MD. | | 12b. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)
Housewife | |
| 13b. COUNTY
BALTIMORE | | 13c. CITY OR TOWN
BALTIMORE | |
| 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS
140 W. LAFAYETTE AVE. | |
| 14. FATHER'S NAME FIRST MIDDLE LAST
Samuel Baker | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST
Margaret Schreck | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)
No | | 16b. SOCIAL SECURITY NO.
220-34-9837 | |
| 17. INFORMANT
Arthur S. Cummings | | ADDRESS
Glen Burnie, MD | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART 1. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) CARDIOPULMONARY ARREST
0389
DUE TO, OR AS A CONSEQUENCE OF
(b) SEPSIS
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last
DUE TO, OR AS A CONSEQUENCE OF
(c) | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a): | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | |
| 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR
19 | |
| 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | 21d. LOCATION STREET CITY OR TOWN COUNTY STATE | |
| 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | |
| 22a. I certify that (I) (this hospital) attended the deceased from JAN. 25 19 82 , to FEB 19 19 82 , that (I) (we) last saw the deceased alive on FEB 19 19 82 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | |
| 22b. SIGNATURE
John H. Weibel | | DEGREE
MD | |
| 22c. DATE SIGNED
2-19-82 | | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
JOHN H. WEIBEL MD | | 22e. ADDRESS
LUTHERAN HOSPITAL | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)
Burial | | 23b. DATE
23 Feb 82 | |
| 23c. NAME OF CEMETERY OR CREMATORY
Tilghman Meth. Church | | 23d. LOCATION CITY OR TOWN COUNTY STATE
Tilghman Is. MD | |
| 24. FUNERAL DIRECTOR NAME
James S. Kirkley | | 25a. DATE REC'D. BY REGISTRAR
FEB 22 1987 | |
| ADDRESS
Glen Burnie, MD | | 25b. REGISTRAR'S SIGNATURE
James S. Kirkley | |

MEDICAL CERTIFICATION

29

1401 BP

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH | | | | | | | | | | 8 2 0 3 6 5 8 | | | | | | | | | | |
|---|--|--|--|--|---|---|-----------------|--------------|---|--|------------|---|----------|--|----------------|----------------------------|-----------------------|------|--|--|
| 1- FOR
STATE
REGISTRAR | | | REG. NO. | | | | | | | | | | | | | | | | | |
| 1. DECEASED NAME
(TYPE OR PRINT) | | | FIRST
VERA | | MIDDLE
L.aura | | LAST
CUMMINS | | 2a. DATE OF DEATH | | MONTH
2 | | DAY
5 | | YEAR
82 | | 2b. HOUR
3:42 P.M. | | | |
| 3. SEX
Female | | | 4. RACE
White | | 5. DATE OF BIRTH
MONTH
Feb. 3, 1919 | | | YEAR
1919 | | 6. AGE (IN YEARS (LAST BIRTHDAY))
63 | | IF UNDER 1 YEAR
MONTHS
DAYS | | IF UNDER 24 HRS
HOURS
MIN. | | | | | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
Canada | | | 7b. CITIZEN OF WHAT COUNTRY?
USA | | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | | 9. BALTIMORE CITY OR COUNTY OF DEATH
BALTIMORE CITY | | | | | MD. | | | | | | |
| 10. CITY OR TOWN OF DEATH
BALTIMORE | | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
UNION MEMORIAL HOSPITAL | | | | | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
Housewife | | | 12b. KIND OF BUSINESS OR INDUSTRY
none | | | | | | | | |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) | | | | | | | | | | 13d. INSIDE CITY LIMITS?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | | | 13e. STREET ADDRESS
1302 Coulbourne Mill Road | | | | | | |
| 13a. STATE
Maryland | | | 13b. COUNTY
Wicomico | | | 13c. CITY OR TOWN
Salisbury | | | | | | | | | | | | | | |
| 14. FATHER'S NAME
FIRST
Arthur | | | MIDDLE
Francis | | | LAST
Ransom | | | 15. MOTHER'S MAIDEN NAME
FIRST
Alice | | | | | | MIDDLE
Kirk | | | LAST | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
No | | | 16b. SOCIAL SECURITY NO.
(IF YES, GIVE WAR OR DATES)
220-66-3397 | | | 17. INFORMANT
Mr. D. W. Cummins (husband) | | | | | | ADDRESS
same as 13 | | | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART 1. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a). 1830 irreversible hypovolemic shock
DUE TO, OR AS A CONSEQUENCE OF
(b) enterocutaneous fistula
DUE TO, OR AS A CONSEQUENCE OF
(c) metastatic OVARIAN CANCER | | | | | | | | | | APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATH
1 month
13 months | | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH, BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a):
entero vaginal fistula, adrenal insufficiency, anemia | | | | | | | | | | | | | | | | | | | | |
| 19a. DATE OF OPERATION
1-6-82 | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED
ileovaginal fistula | | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | 20b. IF YES, WERE FINDINGS USED
IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | | | | | | | | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | | | | | | | | | | | | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/> | | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | | 21f. LOCATION
STREET
CITY OR TOWN
COUNTY
STATE | | | | | | | | | | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from JAN 6, 19 82, to FEB 5, 19 82, that (I) (we) last saw the deceased alive on FEB 5, 19 82, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) did (did not) view the body after death. | | | | | | | | | | 22b. SIGNATURE
J.D. Littlejohn M.D. | | | | DEGREE | | 22c. DATE SIGNED
2-5-82 | | | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
JOHN D. LITTLEJOHN | | | M.D. | | | 22e. ADDRESS
UNION MEMORIAL HOSPITAL | | | | | | | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)
Burial | | | 23b. DATE
2/9/82 | | | 23c. NAME OF CEMETERY OR CREMATORY
Parsons Cemetery | | | 23d. LOCATION
CITY OR TOWN
COUNTY
STATE | | | | | | | | | | | |
| 24. FUNERAL DIRECTOR
HOLDWAY FUNERAL HOME, Salisbury, Md. | | | | | | | | | | 25a. DATE REC'D. BY REGISTRAR
FEB 11 1982 | | | | 25b. REGISTRAR'S SIGNATURE
James J. [Signature] | | | | | | |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

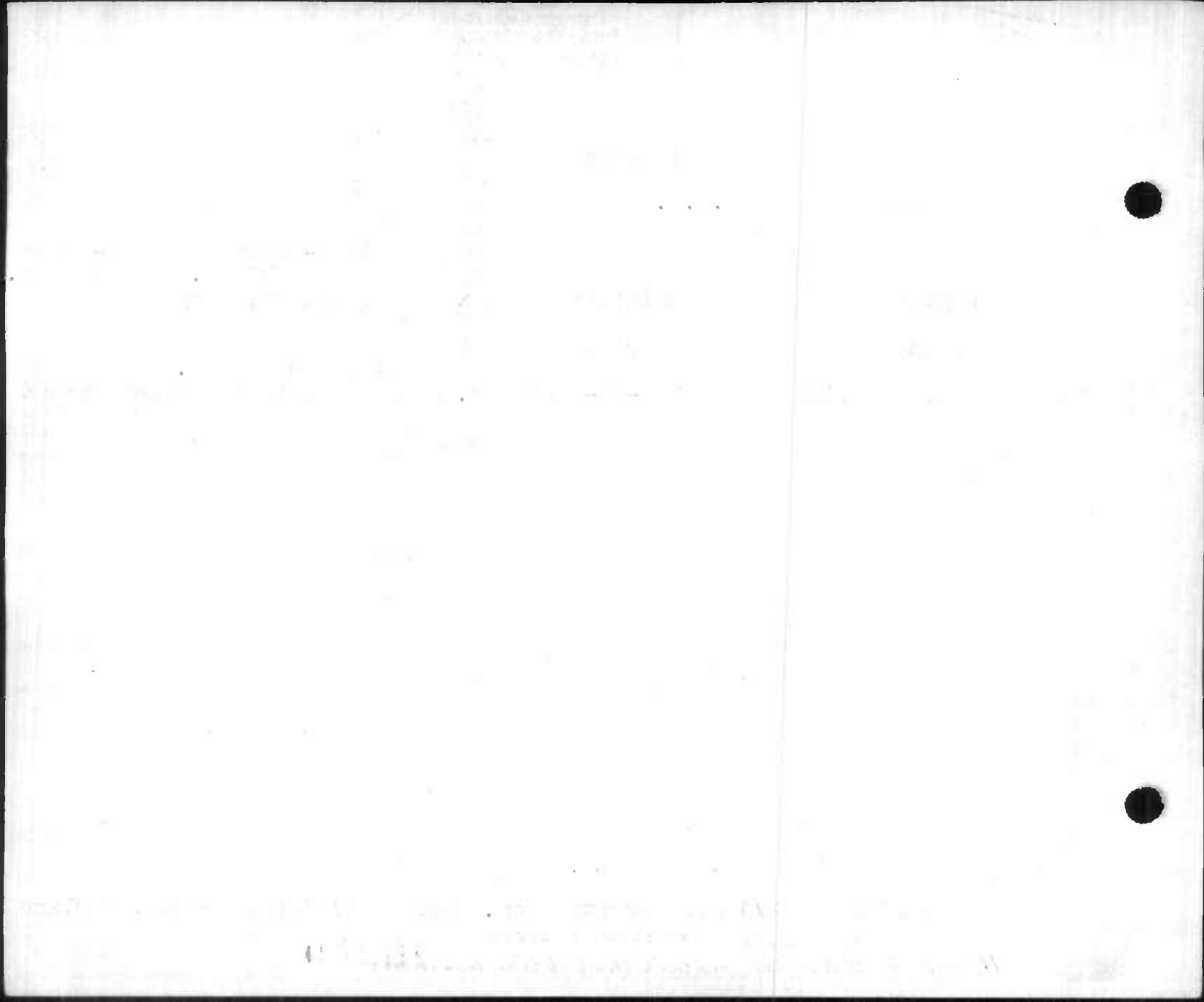
| STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH | | | | | | | | | | 8 2 0 3 6 5 9 | | | | | |
|---|--|--|--|---|--|---|--|---|--------------------------------|--|---|--|--|---------------------|--|
| 1 - FOR STATE REGISTRAR | | | | | | | | | | REG. NO. | | | | | |
| 1. DECEASED NAME (TYPE OR PRINT)
FIRST MIDDLE LAST
ARCHIE W. CUNNINGHAM | | | | | | | | | | 2a. DATE OF DEATH
MONTH DAY YEAR
2 16 82 | | | | 2b. HOUR
6:57 AM | |
| 3. SEX
M | | 4. RACE
WHITE | | 5. DATE OF BIRTH
MONTH DAY YEAR
04 07 05 | | | 6. AGE (IN YEARS LAST BIRTHDAY)
76 YRS. | | IF UNDER 1 YEAR
MONTHS DAYS | | IF UNDER 24 HRS.
HOURS MIN. | | | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
W. Va | | 7b. CITIZEN OF WHAT COUNTRY?
U.S.A | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | | 9. BALTIMORE CITY OR COUNTY OF DEATH
Baltimore City MD. | | | | | | | | |
| 10. CITY OR TOWN OF DEATH
Baltimore | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
UNIVERSITY of Maryland Hosp | | | | | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
Forklift oper | | | 12b. KIND OF BUSINESS OR INDUSTRY
AIRCRAFT | | | | |
| 13. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)
13a. STATE 13b. COUNTY 13c. CITY OR TOWN
Maryland Baltimore Baltimore | | | | | | | | | | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS
1319 Lombard St | | | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
MINOR HARVEY CUNNINGHAM | | | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
MYRTLE TETER | | | | | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
NO | | 16b. SOCIAL SECURITY NO.
(IF YES, GIVE WAR OR DATES)
- | | 17. INFORMANT
ADDRESS
JACK W. DAVIS, Exchange W. Va | | | | | | | | | | | |
| 18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c).
PART 1. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>CARDIO PULMONARY ARREST unknown</u>
<u>0384</u>
DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b) <u>Chronic Lung Disease</u>
DUE TO, OR AS A CONSEQUENCE OF
(c) <u>gram (+) sepsis</u>
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
<u>1 hour</u>
<u>several yrs.</u> | | | | | | | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).
<u>Lung Mass - possible carcinoma</u> | | | | | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1B, PART 1 OR PART 2) | | | | | | | |
| 21d. INJURY OCCURRED
WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>2/15</u> , 19 <u>82</u> , to <u>2/16</u> , 19 <u>82</u> , that (I) (we) lost saw the deceased alive on <u>2/16</u> , 19 <u>82</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | | | | | | | |
| 22b. SIGNATURE
David Patz MD | | | | | | | | DEGREE
MD | | ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> | | 22c. DATE SIGNED
2/16/82 | | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
DAVID PATZ | | | | | | | | 22e. ADDRESS
UNIV. OF MD. HOSPITAL, Balto Md. | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)
Burial | | | | 23b. DATE
2/19/1982 | | 23c. NAME OF CEMETERY OR CREMATORY
Riffle Cemetery | | 23d. LOCATION
Riffle, BRAXTON W. Va | | | | | | | |
| 24. FUNERAL DIRECTOR
NAME
Thomas Skanda | | | | 24b. ADDRESS
2825 Hudson St | | | | 24c. DATE REC'D. BY REGISTRAR
FEB 23 1982 | | 25. REGISTRAR'S SIGNATURE
James Jan Wether | | | | | |

1187-88-203

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

MEDICAL CERTIFICATION

| STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH | | | | | | | | | | REG. NO. 2 0 3 6 6 0 | |
|--|--|---|--|---|--|---|--|--|--|---|--|
| 1- STATE REGISTRAR | | | | | | | | | | | |
| 1. DECEASED NAME
(TYPE OR PRINT) FIRST MIDDLE LAST
Edward Curtis | | | | | | 2a. DATE KNOWN OF DEATH
MONTH DAY YEAR
2 14 1982 | | 2b. HOUR
M
8:30 P. M | | | |
| 3. SEX
Male | | 4. RACE
Black | | 5. DATE OF BIRTH
MONTH DAY YEAR
6 26 1948 | | 6. AGE (IN YEARS)
(LAST BIRTHDAY) YRS.
33 | | 7c. DATE PRONOUNCED DEAD
MONTH DAY YEAR
2 14 1982 | | 2d. HOUR
M
8:30 P. M | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
Maryland | | 7b. CITIZEN OF WHAT COUNTRY?
U.S.A. | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
Baltimore City, MD. | | | | | |
| 10. CITY OR TOWN OF DEATH
Baltimore | | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
4200 Conneticut Avenue (rear) | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)
Clerk-Store | | 12b. KIND OF BUSINESS OR INDUSTRY
Kash-Carry | | | |
| USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) | | | | | | | | | | | |
| 13a. STATE
Maryland | | 13b. COUNTY | | 13c. CITY OR TOWN
Baltimore | | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS
700 N. Augusta Ave.
Baltimore, Maryland 21229 | | | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
Eugene Curtis | | | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
Marie Bembow | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO, OR UNKNOWN)
Yes | | | | 16b. SOCIAL SECURITY NO.
(IF YES, GIVE WAR OR DATES)
Vietnam | | 17. INFORMANT
Baltimore Md. 21229
Mr. Jimmie Curtis 119 Athol Avenue | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I DEATH WAS CAUSED BY:
9654 IMMEDIATE CAUSE (a) Gunshot wound of Head
Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.
(b) _____
(c) _____
DUE TO, OR AS A CONSEQUENCE OF
DUE TO, OR AS A CONSEQUENCE OF | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | | | | | | 20. AUTOPSY?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. EXTERNAL CAUSE WAS
UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH | | | | 21b. TIME OF INJURY
HOUR XXX MONTH DAY YEAR
8 25 P.M. 2 14 1982 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)
subject was shot | | | | | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/>
AT WORK AT WORK | | | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)
street (rear) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE
4200 Conneticut Ave., Balto., Maryland | | | | | |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input checked="" type="checkbox"/> Undetermined manner <input type="checkbox"/> . | | | | | | | | | | | |
| ACTUAL SIGNATURE
Virginia L. Dolan | | | | TITLE (SPECIFY)
M.D. Assistant | | | | MEDICAL EXAMINER
DATE SIGNED 2-15-82 | | | |
| EXAMINER'S NAME
(TYPE OR PRINT)
Virginia L. Dolan, M.D. | | | | ADDRESS
111 Penn Street | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)
Burial | | 23b. DATE
2/19/82 | | 23c. NAME OF CEMETERY OR CREMATORY
Arbutus Mem. Park | | | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
Baltimore County, Maryland | | | |
| 24. FUNERAL DIRECTOR
NAME
Baltimore
HERBERT E. WATSON | | | | | | ADDRESS
Maryland 21216
Funeral Home 3035 W. NORTH | | 25a. DATE REC'D. BY REGISTRAR
FEB 17 1982 | | 25b. REGISTRAR'S SIGNATURE
[Signature] | |



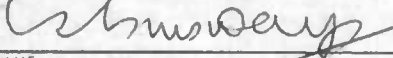
8 2 0 3 6 6

1 - FOR
STATE
REGISTRAR

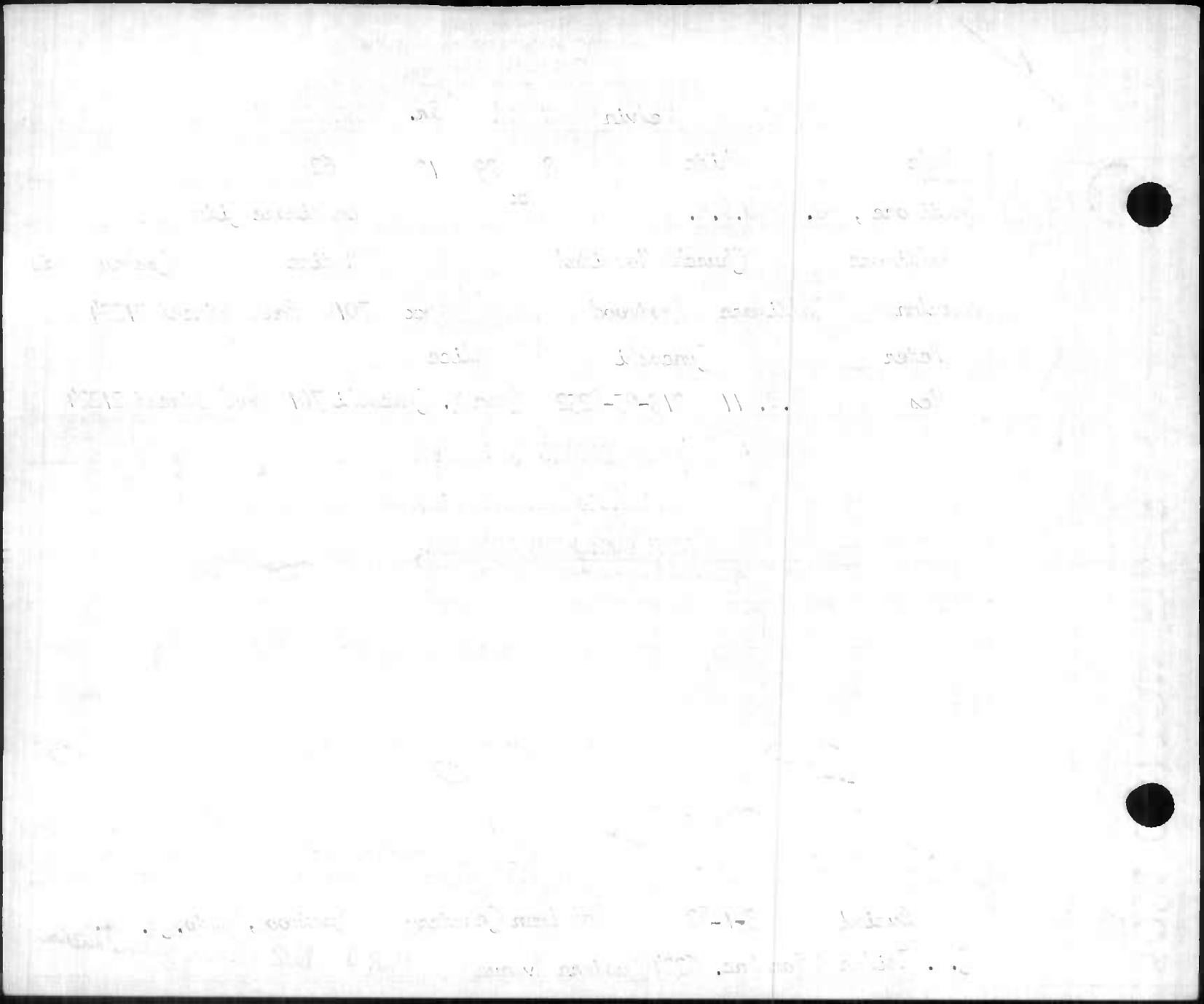
REG. NO.

| | | | | | | | | | | | | | | | |
|---|--|--|--|---|-----------------|---|--|---|--|--------------------------------|--|--------------|--|-----------------------|--|
| 1. DECEASED NAME
(TYPE OR PRINT) | | FIRST
MICHAEL | | MIDDLE
Melvin | LAST
CYNOSKI | 2a. DATE OF DEATH
FEBRUARY 26, 1982 | | MONTH
26 | | DAY
1982 | | YEAR
1982 | | 2b. HOUR
4:30 A.M. | |
| 3. SEX
Male | | 4. RACE
White | | 5. DATE OF BIRTH
MONTH 8 DAY 29 YEAR 19 | | 6. AGE (IN YEARS LAST BIRTHDAY)
62 YRS. | | IF UNDER 1 YEAR
MONTHS DAYS | | IF UNDER 24 HRS.
HOURS MIN. | | | | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
Baltimore, Md. | | 7b. CITIZEN OF WHAT COUNTRY?
U.S.A. | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
Baltimore City MD. | | | | | | | | | |
| 10. CITY OR TOWN OF DEATH
Baltimore | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
Church Hospital | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
Retired | | 12b. KIND OF BUSINESS OR INDUSTRY
Esskay Meats | | | | | | | | | |
| 13a. STATE
Maryland | | 13b. COUNTY
Baltimore | | 13c. CITY OR TOWN
Eastwood | | 13d. INSIDE CITY LIMITS?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 13e. STREET ADDRESS
7010 Bank Street 21224 | | | | | | | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
Peter | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
Alice | | | | | | | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
Yes | | 16b. SOCIAL SECURITY NO.
(IF YES, GIVE YEAR OR DATES)
W.W. 11 213-05-8252 | | 17. INFORMANT
Emma E. Cynoski | | ADDRESS
7010 Bank Street 21224 | | | | | | | | | |

| | | |
|--|--|---|
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) | | APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATH |
| PART 1. DEATH WAS CAUSED BY: | | |
| IMMEDIATE CAUSE (a) <u>CARDIORESPIRATORY FAILURE</u> | | |
| 1561
Conditions, if any, which
gave rise to immediate
cause (a), stating the
underlying cause last. | DUE TO, OR AS A CONSEQUENCE OF | |
| | (b) <u>ADVANCED CARCINOMA COMMON</u> | |
| | DUE TO, OR AS A CONSEQUENCE OF
(c) <u>BILE DUCT WITH JAUNDICE</u> | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) | | |

| | | | |
|--|--|---|--|
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) | | | |
| 19a. DATE OF OPERATION | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1b. PART 1 OR PART 2) | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK AT WORK | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | |
| 22a. I certify that (I <input checked="" type="checkbox"/> this hospital) attended the deceased from FEBRUARY 3 19 82, to FEBRUARY 26 19 82, that (I <input checked="" type="checkbox"/> saw the deceased alive on FEBRUARY 26 19 82, and that in my <input checked="" type="checkbox"/> opinion death occurred on the date and hour and from the causes stated above, (I <input type="checkbox"/> did not) view the body after death. | | | |
| 22b. SIGNATURE
 | DEGREE
M.D. | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> | 22c. DATE SIGNED
2/26/82 |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
GOPAL GURUSWAMY, M.D. | | 22e. ADDRESS
CHURCH HOSPITAL CORPORATION
100 NORTH BROADWAY, BALTIMORE, MD 21231 | |

| | | | |
|---|----------------------------|--|---|
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY) <i>Burial</i> | 23b. DATE
<i>3-1-82</i> | 23c. NAME OF CEMETERY OR CREMATORY
<i>Oak Lawn Cemetery</i> | 23d. LOCATION
CITY OR TOWN <i>Eastwood, Balto</i> COUNTY <i>MD</i> STATE <i>MD</i> |
| 24. FUNERAL DIRECTOR
NAME <i>C.S. Zeiler & Son Inc.</i> ADDRESS <i>6224 Eastern Avenue</i> | | 25a. DATE REC'D. BY REGISTRAR
<i>MAR 1 1982</i> | 25b. REGISTRAR
<i>James J. Smith</i> |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

DHMH - 16 50M 1/81
(VRA 15, 4)

1 - FOR
STATE
REGISTRAR

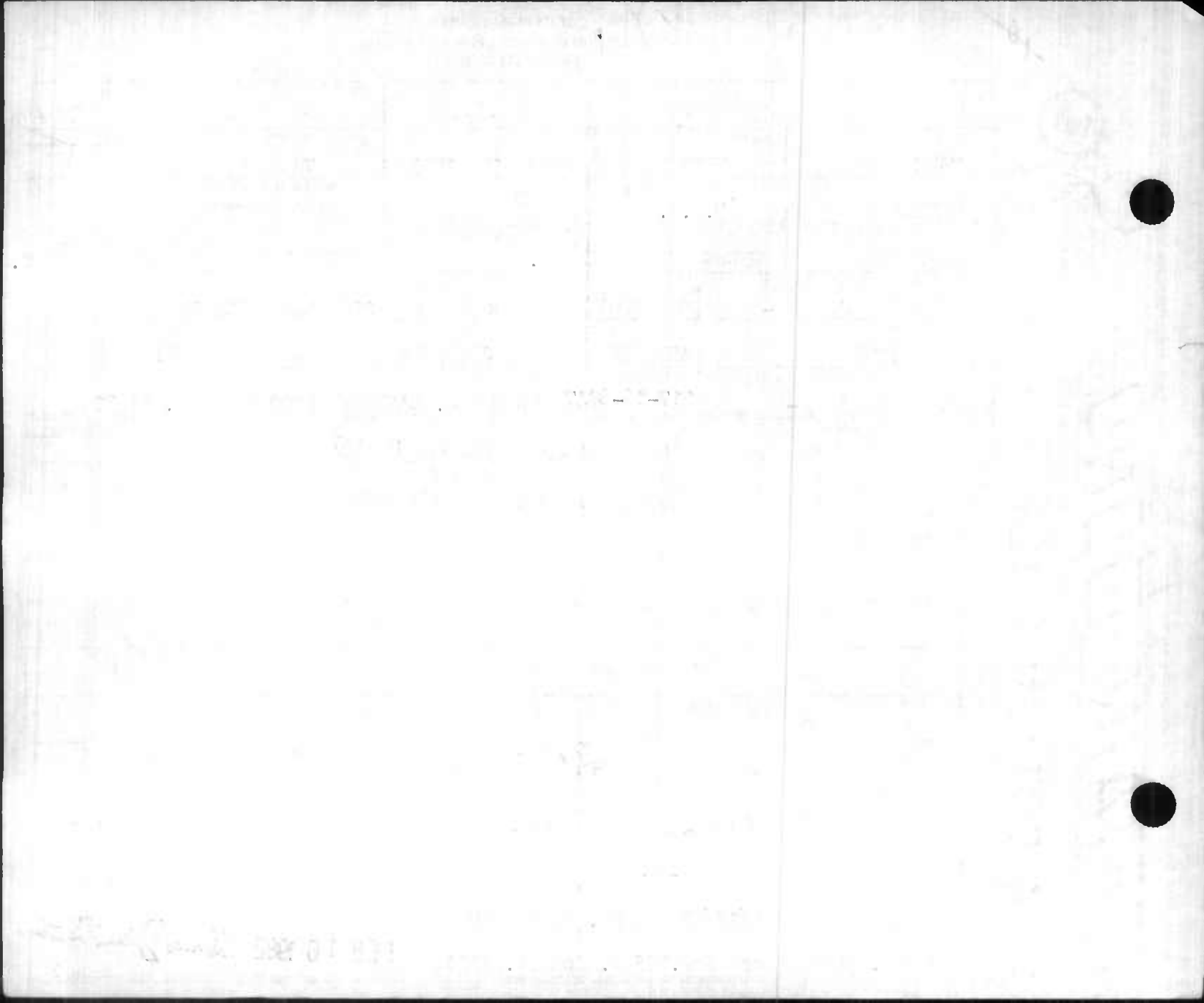
STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 2 0 3 0 6 2

REG. NO.

| | | | | | |
|---|--|---|---|--|--|
| 1. DECEASED NAME
(TYPE OR PRINT)
FIRST MIDDLE LAST
ADAM F. DANIELAK | | | 2a. DATE OF DEATH
MONTH DAY YEAR
02-11-82 | | 2b. HOUR
8:10 PM |
| 1. SEX
MALE | 4. RACE
WHITE | 5. DATE OF BIRTH
MONTH DAY YEAR
JUNE 17 1903 | | 6. AGE (IN YEARS LAST BIRTHDAY)
78 YRS | IF UNDER 1 YEAR
MONTHS DAYS
IF UNDER 24 HRS
HOURS MIN. |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
MARYLAND | 7b. CITIZEN OF WHAT COUNTRY?
U.S.A. | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 9. BALTIMORE CITY OR COUNTY OF DEATH
BALTIMORE CITY MD. | | |
| 10. CITY OR TOWN OF DEATH
BALTIMORE | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
CHURCH HOSPITAL INC. | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
MACHINIST | | 12b. KIND OF BUSINESS OR INDUSTRY
Crown Cork & Seal Co |
| 13a. STATE
MARYLAND | 13b. COUNTY
- | 13c. CITY OR TOWN
BALTIMORE | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | 13e. STREET ADDRESS
2200 BANK STREET | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
JOSEPH DANIELAK | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
JOSEPHINE PUCHALSKI | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
NO | 16b. SOCIAL SECURITY NO.
(IF YES, GIVE WAR OR DATES)
217-16-6847 | 17. INFORMANT ADDRESS
AGNES C. DANIELAK 2200 BANK ST. 21231 | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART 1. DEATH WAS CAUSED BY:
1952
IMMEDIATE CAUSE (a) Cardiorespiratory arrest
DUE TO, OR AS A CONSEQUENCE OF (b) Abdominal Cancer
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(c) | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input type="checkbox"/> | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | |
| 22a. I certify that (if <u>this hospital</u>) attended the deceased from <u>2/02</u> 19 <u>82</u> , to <u>2/11</u> 19 <u>82</u> , that (I <u>(we)</u>) last saw the deceased alive on <u>2/11</u> 19 <u>82</u> , and that in (my <u>(our)</u>) opinion death occurred on the date and hour and from the causes stated above, (I <u>(we)</u>) (did) (did not) view the body after death. | | | | | |
| 22b. SIGNATURE
Dr. Edwards | | DEGREE
MD | | 22c. DATE SIGNED
2/11/82 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
DR. W. EDWARDS XX M.D. | | 22e. ADDRESS
CHURCH HOSPITAL CORPORATION
100 N. BROADWAY BALTIMORE, MD. 21231 | | | |
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)
BURIAL | 23b. DATE
2/15/82 | 23c. NAME OF CEMETERY OR CREMATORY
ST. STANISLAUS CEMETERY | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
BALTIMORE MARYLAND | |
| 24. FUNERAL DIRECTOR
NAME ADDRESS
George A. Weber & Sons Inc. 705 S. Ann St. 21231 | | 25a. DATE RECD. BY REGISTRAR
FEB 16 1982
25b. REGISTRAR'S SIGNATURE
James Nathan | | | |

BP



MEDICAL CERTIFICATION

DHMH-16 30M 2/80
(VRA 15, 4)

0843 BP.



RECEIVED
JAN 15 1934

OFFICIAL



RECEIVED
JAN 15 1934

Item 7a g566 4/21/82 gJ

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 2 0 3 6 6 4

1 - FOR
STATE
REGISTRAR

REG. NO.

| | | | | | | | |
|---|--|---|---|---|--------------------------------|--|--|
| 1. DECEASED NAME
(TYPE OR PRINT)
FIRST MIDDLE LAST
Wilbur H DANmeyer | | | 2a. DATE OF DEATH
MONTH DAY YEAR
2-20-82 | | 2b. HOUR
A M
8:30 | | |
| 3. SEX
male | | 4. RACE
White | | 5. DATE OF BIRTH
MONTH DAY YEAR
6 2 05 | | 6. AGE (IN YEARS LAST BIRTHDAY)
YRS. MONTHS DAYS
76 | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
Maryland | | 7b. CITIZEN OF WHAT COUNTRY?
USA | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
Baltimore City MD. | |
| 10. CITY OR TOWN OF DEATH
Baltimore | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
Federal Hill Nursing Center | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
unknown | | 12b. KIND OF BUSINESS OR INDUSTRY
unknown | |
| 13a. STATE
md | | 13b. COUNTY
Baltimore | | 13c. CITY OR TOWN
Baltimore | | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 13e. STREET ADDRESS
1708 Light St. | | 14. FATHER'S NAME
FIRST MIDDLE LAST
unknown - Danmeyer | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
unknown Laura unknown | | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
NO | |
| 16b. SOCIAL SECURITY NO.
220-07-3685 | | 17. INFORMANT
Richard Knapp | | 17a. ADDRESS
1708 Light St. Balt. md. | | 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART 1. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Squamous cell CA of larynx
1619
DUE TO, OR AS A CONSEQUENCE OF
(b) Congestion & Shortness of breath
DUE TO, OR AS A CONSEQUENCE OF
(c) | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a). | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | |
| 21d. INJURY OCCURRED
WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) last saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | |
| 22b. SIGNATURE
[Signature] | | DEGREE
MD | | ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> | | 22c. DATE SIGNED
2-22-82 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
Morris Sporn | | 22e. ADDRESS
844 N. Carey St 21217 | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)
Burial | | 23b. DATE
Feb. 23, 1982 | | 23c. NAME OF CEMETERY OR CREMATORY
Woodlawn Cemetery | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
Baltimore Co. Maryland | |
| 24. FUNERAL DIRECTOR
NAME
MR Cully F.H. | | ADDRESS
130 South Ave. Balt. md. | | 25a. DATE REC'D. BY REGISTRAR
FEB 24 1982 | | 25b. REGISTRAR'S SIGNATURE
Frances Jean Warden | |

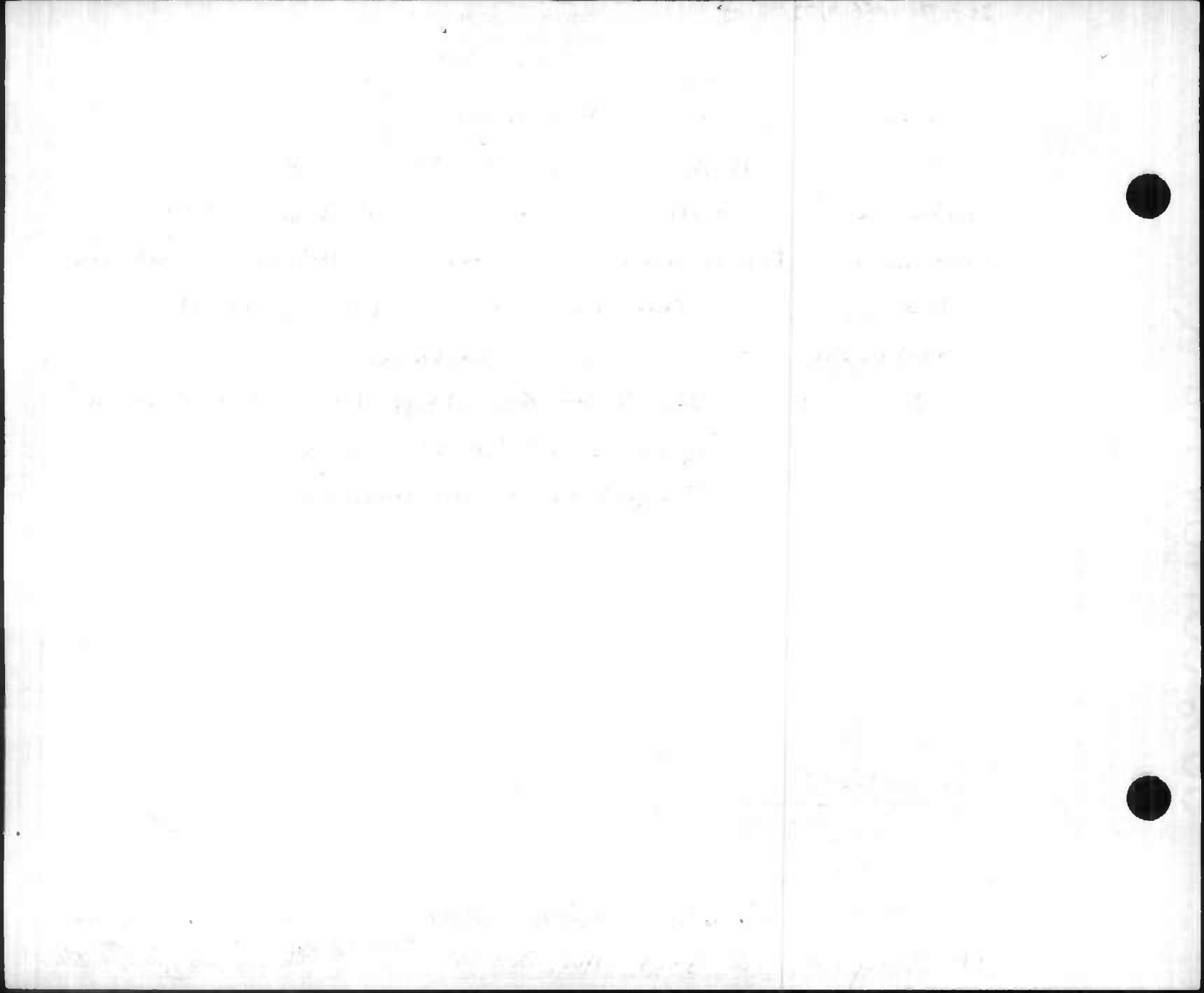
MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked as item 18 shows any injury, or other traumatic event, the medical examiner must be notified immediately.



STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 2 0 3 6 5

1. FOR
STATE
REGISTRAR

REG. NO.

| | | | | | | | | | | | |
|---|--|--|--|---|--|--|--|---|--|---|--|
| 1. DECEASED NAME
(TYPE OR PRINT)
ANTONIO | | FIRST
ANTONIO | | MIDDLE
DANNA | | LAST
DANNA | | 2a. DATE OF DEATH
MONTH DAY YEAR
FEBRUARY 14, 1982 | | 2b. HOUR
7:00pm | |
| 3. SEX
Male | | 4. RACE
White | | 5. DATE OF BIRTH
MONTH DAY YEAR
6 9 1902 | | 6. AGE (IN YEARS LAST BIRTHDAY)
79 YRS. | | 7. IF UNDER 1 YEAR
MONTHS DAYS HOURS MIN. | | 8. IF OVER 1 YEAR
MONTHS DAYS HOURS MIN. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
Italy | | 7b. CITIZEN OF WHAT COUNTRY?
U.S.A. | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
Baltimore City MD. | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)
Inspector | | 12b. KIND OF BUSINESS OR INDUSTRY
Beth. Steel | |
| 10. CITY OR TOWN OF DEATH
Baltimore | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
Church Hospital Corporation | | 13a. INSIDE CITY LIMITS?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 13b. STREET ADDRESS
8051 Parkhaven Road | | 13c. CITY OR TOWN
Dundalk | | 13d. STATE
Maryland | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
Alfonzo Danna | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
Anna Marino | | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)
No | | 16b. SOCIAL SECURITY NO.
213-07-4767 | | 17. INFORMANT
Vera M. Danna | | 17b. ADDRESS
8051 Parkhaven Road Balto., MD. 21222 | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART 1. DEATH WAS CAUSED BY:
1629 IMMEDIATE CAUSE (a) CANCER OF THE RIGHT LUNG WITH METASTASIS
DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b) _____
DUE TO, OR AS A CONSEQUENCE OF
(c) _____ | | | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a):
ARTERIOSCLEROTIC CARDIOVASCULAR DISEASE | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK AT WORK | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) | | 22a. I certify that (I) (this hospital) attended the deceased from FEBRUARY 2, 1982 , to FEBRUARY 14, 1982 , that (I) (we) last saw the deceased alive on FEBRUARY 14, 1982 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did not) view the body after death. | | 22b. SIGNATURE
A.F. NOUR MD. | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
A.F. NOUR MD. | | 22e. ADDRESS
CHURCH HOME CORP.
100 NORTH BROADWAY BALTIMORE, M D. 21231 | | 22c. DATE SIGNED
2-14-82 | | 22f. DEGREE
MD | | 22g. ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | 22h. SIGNATURE
Anna J. [Signature] | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)
Burial | | 23b. DATE
2/18/1982 | | 23c. NAME OF CEMETERY OR CREMATORY
Oak Lawn | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
Baltimore Maryland | | 24. FUNERAL DIRECTOR
NAME
Duda-Ruck, Inc. | | 25a. DATE REC'D. BY REGISTRAR
FEB 16 1982 | |
| 24. FUNERAL DIRECTOR
ADDRESS
7922 Wise Avenue Dundalk, MD. 21222 | | 25b. REGISTRAR'S SIGNATURE
[Signature] | | 25c. REGISTRAR'S SIGNATURE
[Signature] | | 25d. REGISTRAR'S SIGNATURE
[Signature] | | 25e. REGISTRAR'S SIGNATURE
[Signature] | | 25f. REGISTRAR'S SIGNATURE
[Signature] | |

MEDICAL CERTIFICATION

61114 A1 - inc 1000

2000

TO HOSPITAL OR ATTENDING PHYSICIAN. The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

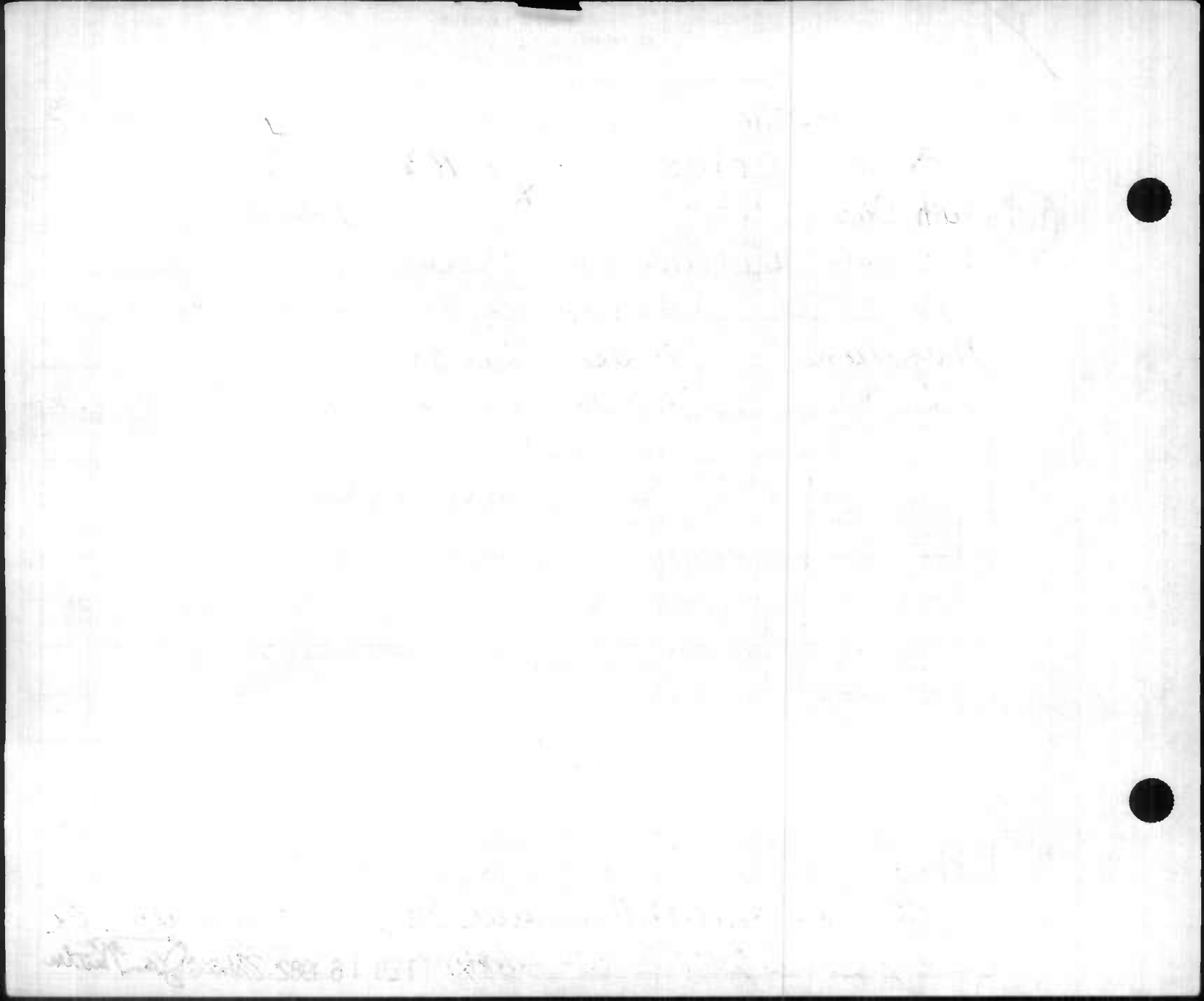
1 - FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 2 0 3 0 0 0

REG. NO.

| | | | | | | | | | |
|---|--|---|--|--|--|---|--|---|--|
| 1. DECEASED NAME
(TYPE OR PRINT)
FIRST MIDDLE LAST
Adella Davis | | | 2a. DATE OF DEATH
MONTH DAY YEAR
February 14 1982 | | | 2b. HOUR
8:30 M | | | |
| 3. SEX
Female | | 4. RACE
Black | | 5. DATE OF BIRTH
MONTH DAY YEAR
10 3 1893 | | 6. AGE (IN YEARS LAST BIRTHDAY)
89 | | 7. UNDER 1 YEAR IF UNDER 24 HRS.
MONTHS DAYS HOURS MIN. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
South Car | | 7b. CITIZEN OF WHAT COUNTRY?
U.S.A. | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH.
Balto City MD. | | | |
| 10. CITY OR TOWN OF DEATH
Baltimore | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
Lutheran Hospital of Maryland | | | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE) | | 12b. KIND OF BUSINESS OR INDUSTRY | |
| 13a. STATE
MD. | | 13b. COUNTY | | 13c. CITY OR TOWN
Baltimore | | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS
140 W. Lafayette Ave | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
Maple | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
Linda | | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)
Unknown | | | | | |
| 16b. SOCIAL SECURITY NO.
215054094 | | 17. INFORMANT
ADDRESS
David Davis (Relative) 3818 Ferndale Av. | | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART 1. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Respiratory arrest
2620
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last }
(b) Severe Malnutrition
(c) Due to, or as a consequence of | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | | | |
| 21d. INJURY OCCURRED
AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET
2/9 | | CITY OR TOWN
19 82 | | COUNTY
2/14 | |
| 21g. I certify that (I) (this hospital) attended the deceased from 2/9 19 82 to 2/14 19 82 , that (I) (we) last saw the deceased alive on 2/14 19 82 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above; (I) (we) (did) (did not) view the body after death. | | | | | | | | | |
| 22a. SIGNATURE
Henry J. Sacerio, M.D. | | DEGREE | | 22b. DATE SIGNED
2/14/82 | | | | 22c. ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
Henry J. Sacerio, M.D. | | 22e. ADDRESS
Lutheran Hospital of Maryland | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)
Burial | | 23b. DATE
2/19/82 | | 23c. NAME OF CEMETERY OR CREMATORY
Crownsville Vet. Cem. | | 23d. LOCATION
CITY OR TOWN
Crownsville, Md. | | COUNTY | |
| 24. FUNERAL DIRECTOR
NAME
Leoy O. Dett | | ADDRESS
4600 Liberty | | 25a. DATE REC'D. BY REGISTRAR
FEB 16 1982 | | 25b. REGISTRAR'S SIGNATURE
James Van Thunen | | | |

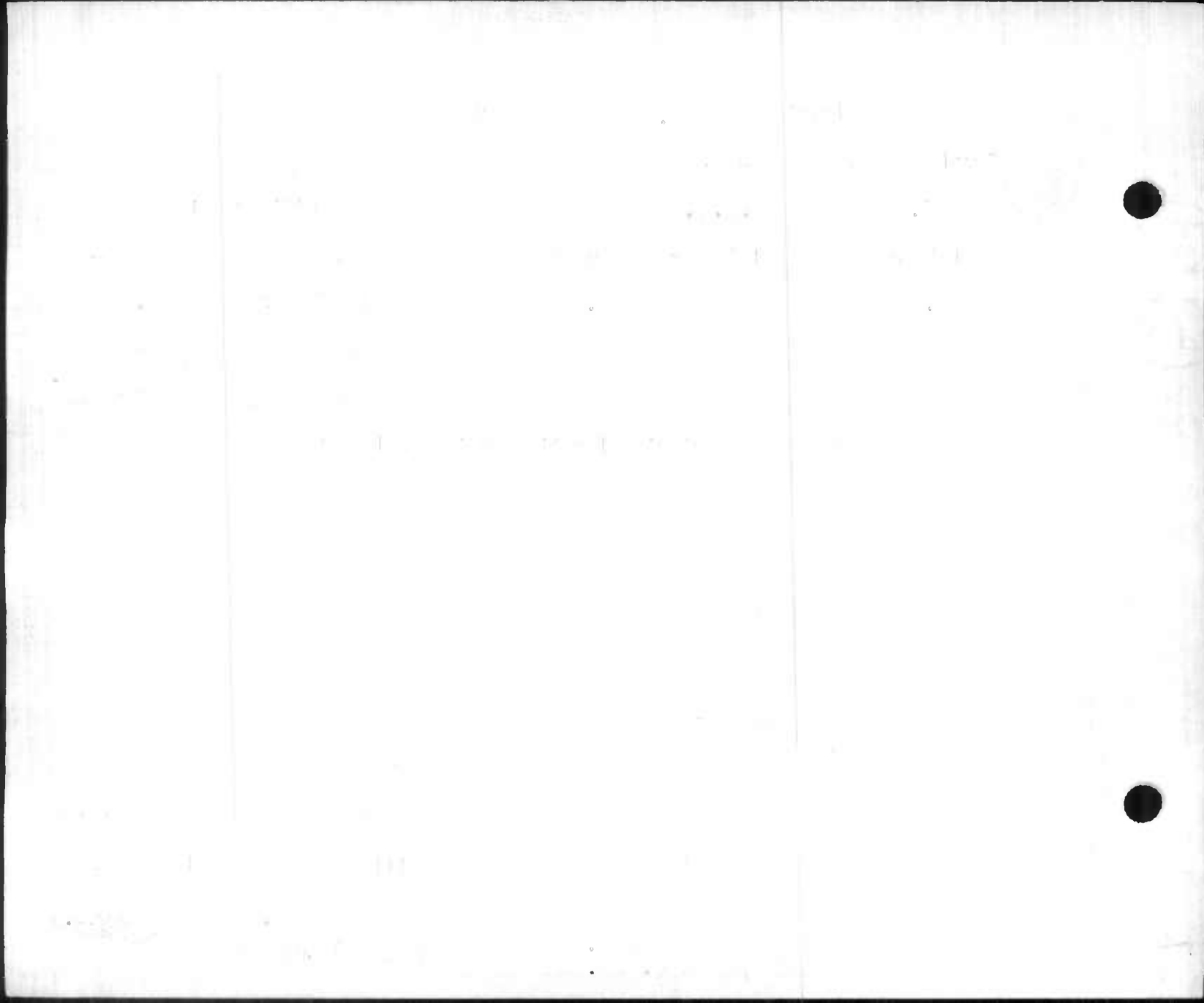
BP



TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 24 HOURS AFTER DEATH. WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

MEDICAL CERTIFICATION

| STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH | | | | | | | | | | REG. NO. 2 0 3 6 6 7 | |
|---|-------------------------|--|---|---|--------------------------------|--|--|---|--|--|--|
| 1. DECEASED NAME
(TYPE OR PRINT) Alverta L. Davis | | | | | | 2a. DATE KNOWN OF DEATH
ESTIMATED <input checked="" type="checkbox"/> MONTH DAY YEAR 2 6 19 82 | | 2b. HOUR M | | | |
| 3. SEX
Female | 4. RACE
White | 5. DATE OF BIRTH
MONTH DAY YEAR 11-19-05 | 6. AGE (IN YEARS)
(LAST BIRTHDAY) 76 YRS. | IF UNDER 1 YR.
MONTHS DAYS | IF UNDER 24 HRS.
HOURS MIN. | 2c. DATE PRONOUNCED DEAD
MONTH DAY YEAR 2 8 19 82 | | 2d. HOUR 4:43 P. M | | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
MD. | | 7b. CITIZEN OF WHAT COUNTRY?
U.S.A. | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
Baltimore City, MD. | | | | | |
| 10. CITY OR TOWN OF DEATH
Baltimore | | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
1627 Gorsuch Avenue | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)
Homemaker | | 12b. KIND OF BUSINESS OR INDUSTRY
- | | | |
| 13a. STATE
MD. | | 13b. COUNTY | | 13c. CITY OR TOWN
Balto. | | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS
1627 Gorsuch Ave. | | | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
Frank Lucas | | | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
Catherine - | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO, OR UNKNOWN)
no | | 16b. SOCIAL SECURITY NO.
unknown | | 17. INFORMANT
3028 Elkader Rd.
Matilda Darrough (Administrator) | | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I DEATH WAS CAUSED BY:
4292 IMMEDIATE CAUSE (a) Arteriosclerotic cardiovascular disease
DUE TO, OR AS A CONSEQUENCE OF
(b) _____
DUE TO, OR AS A CONSEQUENCE OF
(c) _____
Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1. | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | | | | 20. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 21a. EXTERNAL CAUSE WAS
UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH | | | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) | | | | | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK AT WORK | | | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | | | |
| 22a. I certify that I took charge of the remains described above, held in death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> .
Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion | | | | | | | | | | | |
| ACTUAL SIGNATURE
<i>Thomas D. Smith</i> | | | | TITLE (SPECIFY)
Deputy Chief | | | | DATE SIGNED
2/9/82 | | | |
| EXAMINER'S NAME
(TYPE OR PRINT) Thomas D. Smith, M.D. | | | | ADDRESS
111 Penn St. Balto., MD. | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY) Burial | | | | 23b. DATE
2/18/82 | | 23c. NAME OF CEMETERY OR CREMATORY
Gardens of Faith | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
Balto. MD. | | | |
| 24. FUNERAL DIRECTOR
Schumnek Funeral Home, Inc.
3331 Brehms Lane, Balto. Md. 21213 | | | | | | 25a. DATE REC'D. BY REGISTRAR
FEB 19 1982 | | 25b. REGISTRAR'S SIGNATURE
<i>Charles J. Smith</i> | | | |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the health officer after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

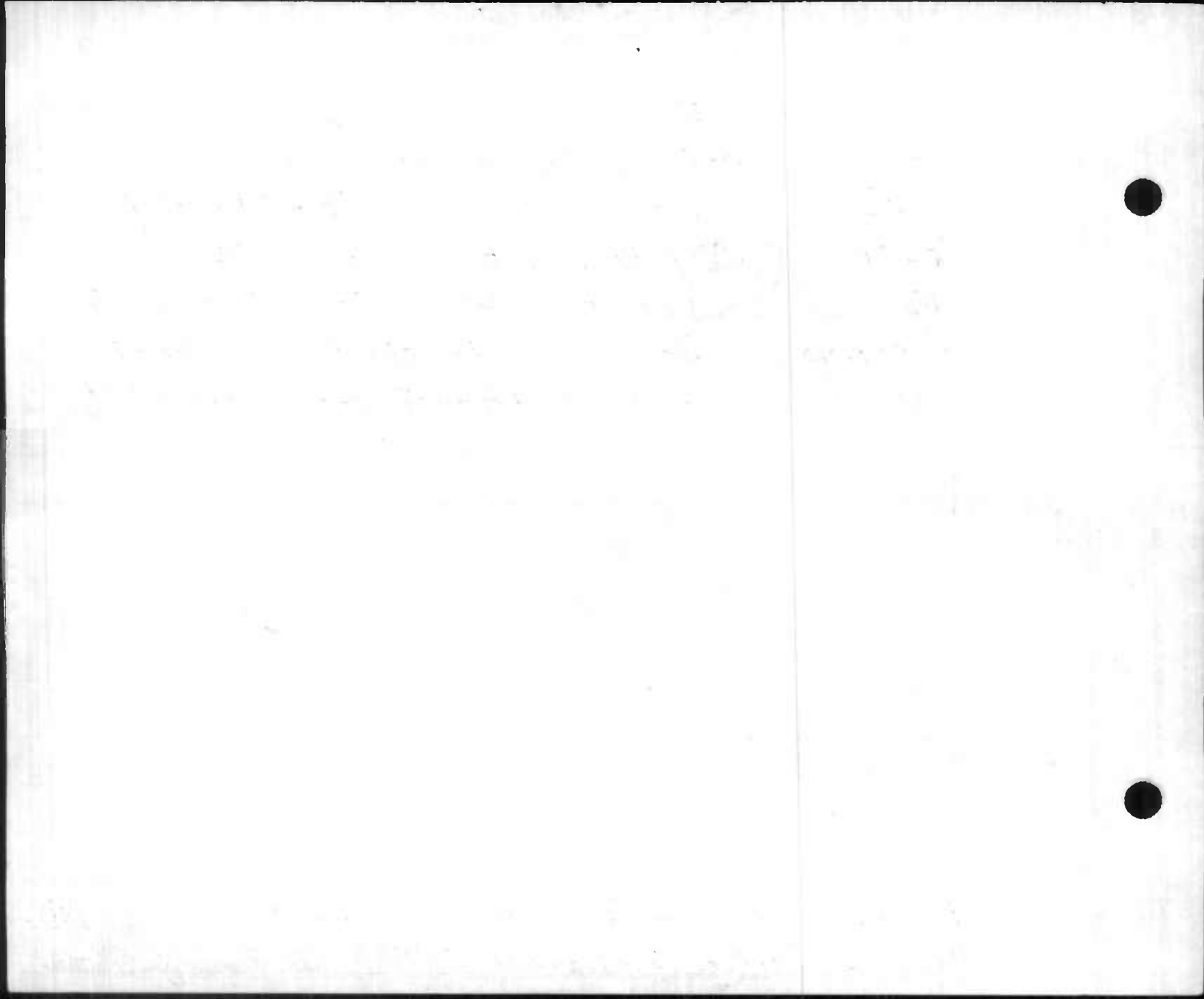
STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 2 0 3 6 6 8

REG. NO.

1 - FOR
STATE
REGISTRAR

| | | | | | | | | | | |
|---|--|--|---|--|---|--|--|---|--|-------|
| 1 DECEASED NAME
(TYPE OR PRINT)
FIRST MIDDLE LAST
Anna E. Davis | | | 2a DATE OF DEATH
MONTH DAY YEAR
12 27 82 | | | 2b HOUR
3 A M | | | | |
| 3 SEX
F | | 4 RACE
WHITE | | 5 DATE OF BIRTH
MONTH DAY YEAR
SEPT 26 1889 | | 6 AGE (IN YEARS LAST BIRTHDAY)
92 YRS | | 7 IF UNDER 1 YEAR
MONTHS DAYS
IF UNDER 24 HRS
HOURS MIN. | | |
| 7a BIRTHPLACE
(STATE OR FOREIGN COUNTRY)
MD. | | 7b CITIZEN OF WHAT COUNTRY?
U.S.A. | | 8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9 BALTIMORE CITY OR COUNTY OF DEATH
BALTO. CITY MD. | | | | |
| 10 CITY OR TOWN OF DEATH
BALTO. | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
CITY Hosp. N.H. | | | | 12a USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
HOUSEWIFE | | 12b KIND OF BUSINESS OR INDUSTRY | | |
| 13a STATE
MD. | | | 13b COUNTY | | 13c CITY OR TOWN
BALTO. | | 13d INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e STREET ADDRESS
3011 O'DONNELL ST. | |
| 14 FATHER'S NAME
FIRST MIDDLE LAST
JOHANN DAVIS | | | 15 MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
ELIZABETH SENFT | | | | | | | |
| 16a WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
NO | | (IF YES, GIVE WAR OR DATES) | | 16b SOCIAL SECURITY NO.
213-07-0102 | | 17 INFORMANT
MARGARET CRAIG | | ADDRESS
JAME 2124 | | |
| 18 CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>Cardiopulmonary Arrest</u>
2500
DUE TO, OR AS A CONSEQUENCE OF
(b) <u>CAD/CHF</u>
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last
DUE TO, OR AS A CONSEQUENCE OF
(c) <u>Pneumonia</u> | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 11a
<u>cellulitis</u> | | | | | | | | | | |
| 19a DATE OF OPERATION | | | 19b CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | |
| 21a ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | | 21b TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | | 21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | | |
| 21d INJURY OCCURRED
WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | | 21e PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | | 21f LOCATION
STREET | | CITY OR TOWN | | STATE |
| 22a I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) last saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death. | | | | | | | | | | |
| 22b SIGNATURE
<u>Bruce Kinross</u> | | | DEGREE | | | ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> | | | 22c DATE SIGNED
2/27/81 | |
| 22d PHYSICIAN'S NAME (TYPE OR PRINT)
Bruce Kinross | | | 22e ADDRESS
BC 14 | | | | | | | |
| 23a BURIAL, CREMATION, REMOVAL
(SPECIFY)
BURIAL | | | 23b DATE
3-2-82 | | 23c NAME OF CEMETERY OR CREMATORY
BALTIMORE CEM. | | 23d LOCATION
CITY OR TOWN
BALTO. | | COUNTY
STATE
MD. | |
| 24 FUNERAL DIRECTOR
NAME
THOMAS J. SHARDA | | | | | | ADDRESS
2829 HUDSON ST | | 25a DATE REC'D. BY REGISTRAR
MAR 1 1982 | | |
| 25b REGISTRAR'S SIGNATURE
<u>James J. Nathan</u> | | | | | | | | | | |



BP

DHMH-16 50M 1/81
(VRA 15, 4)

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. This may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

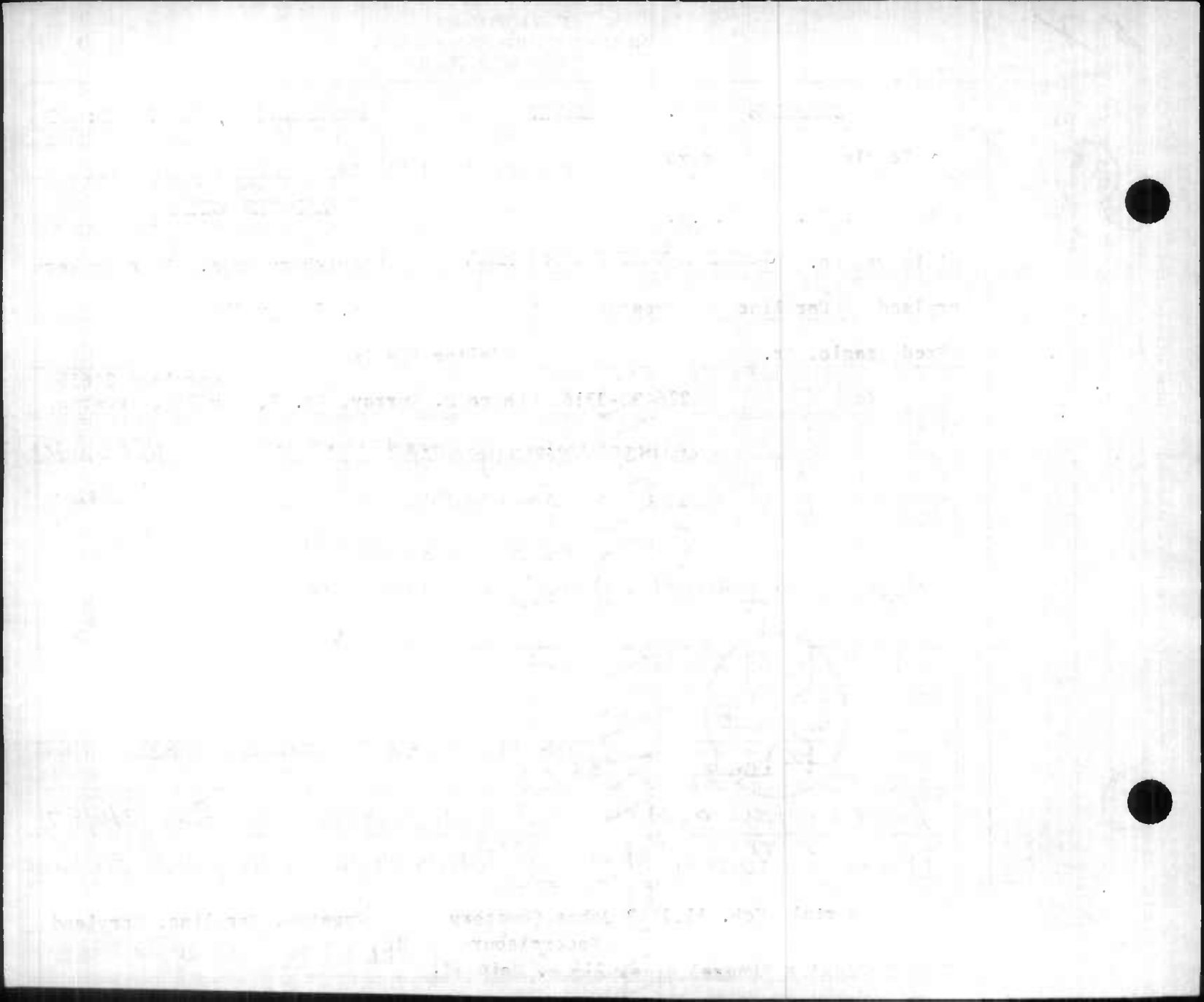
IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

FOR
1. STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 2 0 3 6 6 9

REG. NO.

| | | | | | | | | | | | |
|---|--|--|--|---|--|---|---|---|--|---|--|
| 1. DECEASED NAME
(TYPE OR PRINT)
CORRINE T. DAVIS | | | 2a. DATE OF DEATH
MONTH DAY YEAR
FEBRUARY 6, 1982 | | | 2b. HOUR
2:45P M | | | | | |
| 3. SEX
Female | | 4. RACE
Negro | | 5. DATE OF BIRTH
MONTH DAY YEAR
December 28, 1923 | | | 6. AGE (IN YEARS LAST BIRTHDAY)
YRS. MONTHS DAYS
58 | | | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
Modest Town, Va. | | 7b. CITIZEN OF WHAT COUNTRY?
U.S.A. | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | | 9. BALTIMORE CITY OR COUNTY OF DEATH
BALTIMORE CITY MD. | | | | |
| 10. CITY OR TOWN OF DEATH
Baltimore, Md. | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
JOHNS HOPKINS HOSPITAL | | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
Saulsbury Bros. | | | 12b. KIND OF BUSINESS OR INDUSTRY
Food Brokers | | | |
| 13a. STATE
Maryland | | 13b. COUNTY
Caroline | | 13c. CITY OR TOWN
Preston | | 13d. INSIDE CITY LIMITS?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 13e. STREET ADDRESS
Rt. 2, Box 298 | | | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
Fred Teagle, Sr. | | | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
Adeline Custis | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
No | | 16b. SOCIAL SECURITY NO.
(IF YES, GIVE WAR OR DATES)
226-30-3316 | | 17. INFORMANT
ADDRESS
Maryland 21655 | | | | 17. INFORMANT
ADDRESS
Laura D. Murray, Rt. 2, Box 298, Preston, | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART 1. DEATH WAS CAUSED BY:
2050 IMMEDIATE CAUSE (a) <u>cardiopulmonary arrest</u> | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
10 minutes | | | |
| DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b) sepsis, meningitis | | | | | | | | 3 days | | | |
| DUE TO, OR AS A CONSEQUENCE OF
(c) Acute myelogenous leukemia | | | | | | | | 9 months | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).
Hypertensive cardiac disease, leukemia, aplasia | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | | | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK AT WORK | | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from Jan 19 , 19 82 , to Feb 6 , 19 82 , that (I) (we) lost
saw the deceased alive on Feb 6 , 19 82 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated
above (I) (we) (did not) view the body after death. | | | | | | | | | | | |
| 22b. SIGNATURE
Diane C. Young, M.D. | | | | | DEGREE
B | | | | | 22c. DATE SIGNED
2/6/82 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
Diane C. Young, M.D. | | | | | 22e. ADDRESS
Johns Hopkins Hospital, Baltimore | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)
Burial | | | 23b. DATE
Feb. 11, 1982 | | 23c. NAME OF CEMETERY OR CREMATORY
Johns Cemetery | | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
Preston, Caroline, Maryland | | | |
| 24. FUNERAL DIRECTOR
NAME
Frampton-Hawkins Funeral Home | | | | | ADDRESS
Federalsburg | | | | | 25a. DATE REC'D. BY REGISTRAR
FEB 11 1982 | |
| | | | | | 25b. REGISTRAR'S SIGNATURE
<i>[Signature]</i> | | | | | | |



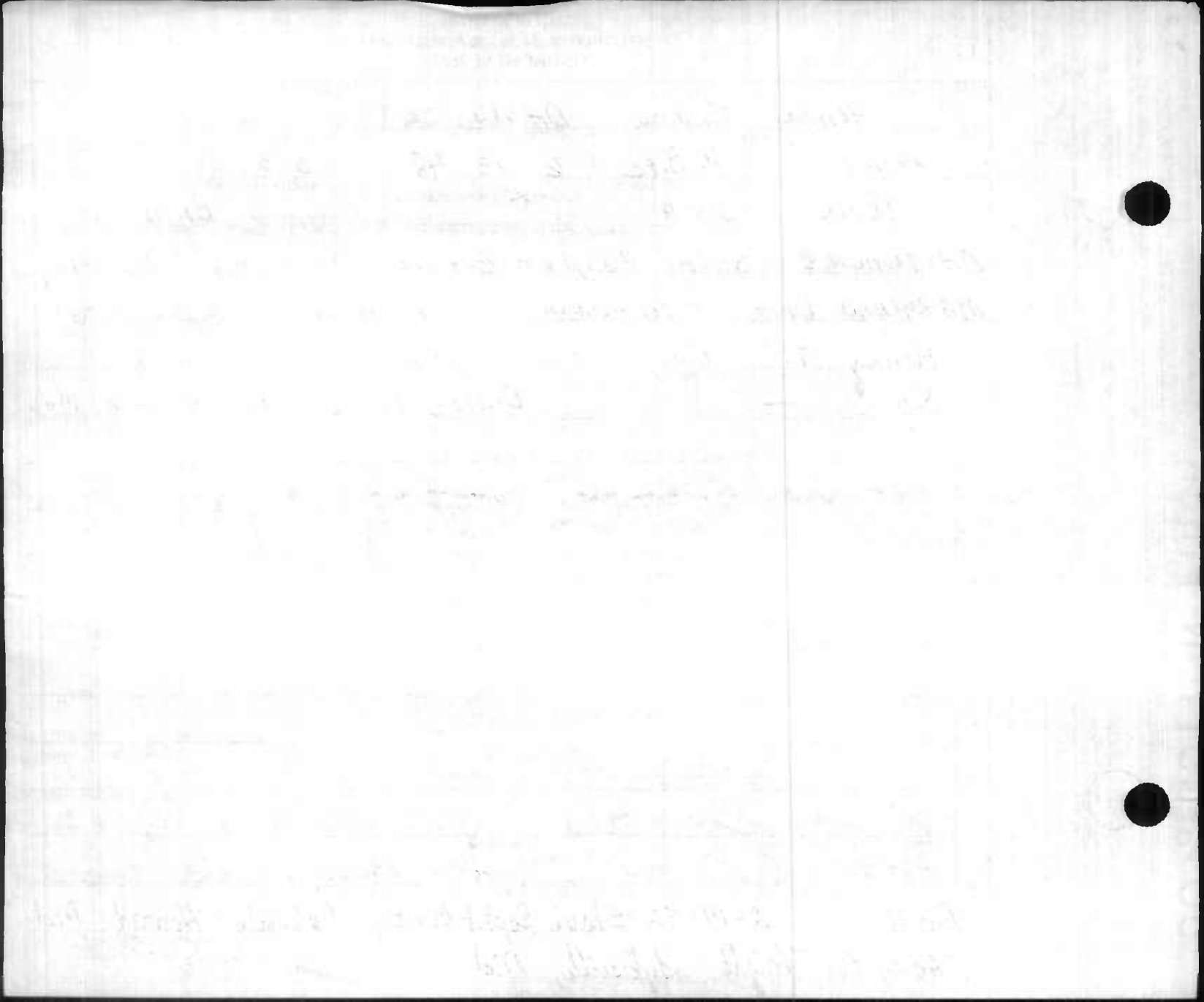
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

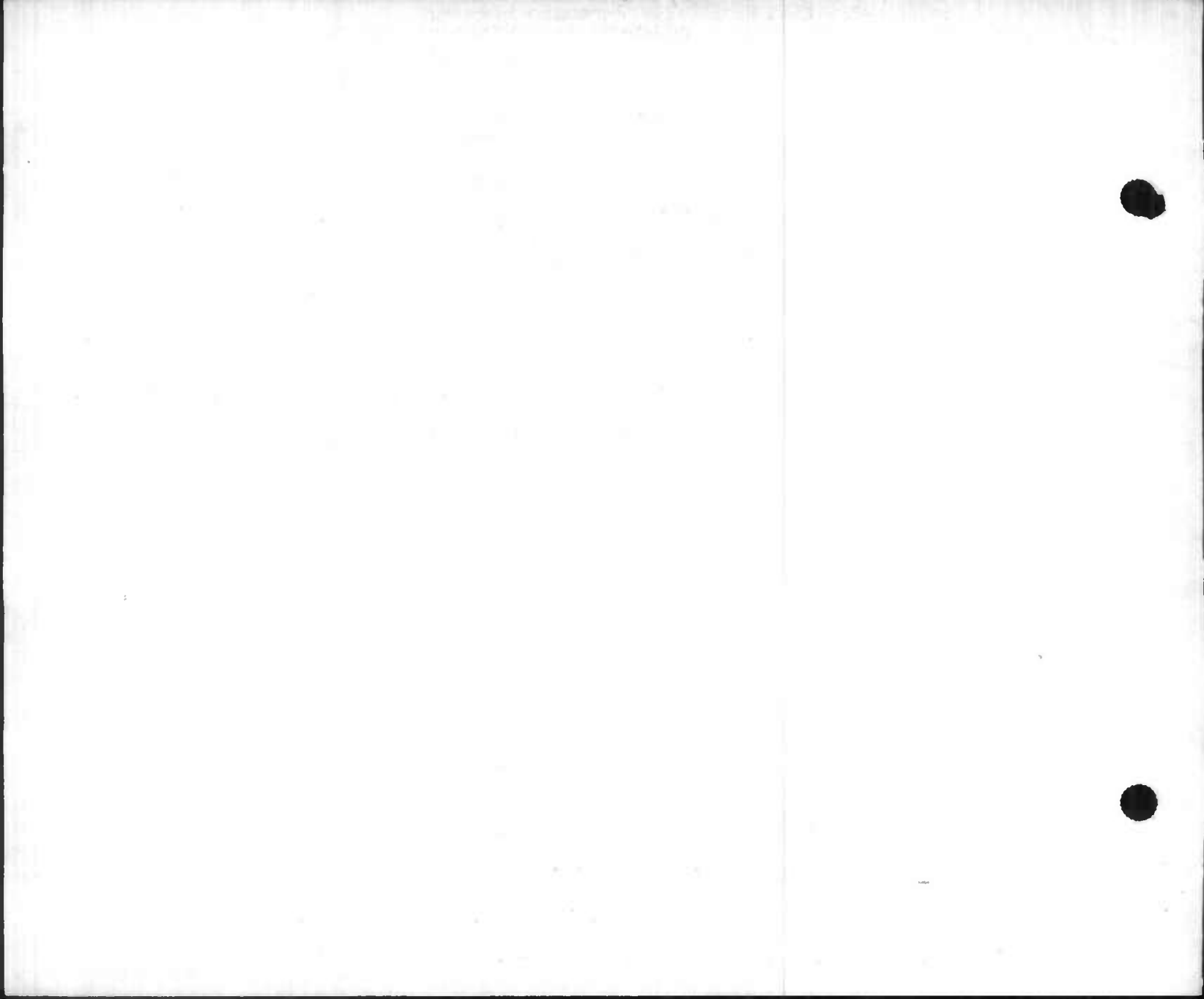
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the medical director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

| STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH | | | | REG. NO. 8 2 0 3 6 7 0 | | | |
|--|--|---|--|--|--|---|--|
| 1. DECEASED NAME (TYPE OR PRINT)
FIRST MIDDLE LAST
<u>Henry Thomas DAVIS, Jr.</u> | | | | 2a. DATE OF DEATH MONTH DAY YEAR
<u>2 11 82</u> | | | |
| 3 SEX
<u>Male</u> | | 4. RACE
<u>White</u> | | 5. DATE OF BIRTH MONTH DAY YEAR
<u>6 13 48</u> | | 2b. HOUR
<u>12 15</u> M | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
<u>TENN</u> | | 7b. CITIZEN OF WHAT COUNTRY?
<u>USA</u> | | 6. AGE (IN YEARS LAST BIRTHDAY)
<u>33</u> YRS. | | 8. IF UNDER 1 YEAR MONTHS DAYS
IF UNDER 24 HRS. HOURS MIN. | |
| 10 CITY OR TOWN OF DEATH
<u>BALTIMORE</u> | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
<u>SINAI HOSP OF BALTO.</u> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
<u>CITY Balto. City MD.</u> | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)
<u>Carpenter</u> | |
| 13a. STATE
<u>MARYLAND</u> | | 13b. CITY OR TOWN
<u>Reisterstown</u> | | 13c. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 13d. STREET ADDRESS
<u>11026 REISTERSTOWN Rd</u> | |
| 14. FATHER'S NAME FIRST MIDDLE LAST
<u>Henry T. Davis Sr</u> | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST
<u>Olga Collins</u> | | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)
<u>No</u> | | | |
| 16b. SOCIAL SECURITY NO.
<u>?</u> | | 17. INFORMANT ADDRESS
<u>Denise Davise Reisterstown, Md.</u> | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART 1. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>Cerebral Edema</u>
<u>1629</u>
DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last
(b) <u>metastatic lung CA</u>
DUE TO, OR AS A CONSEQUENCE OF
(c) _____ | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: _____ | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK OR NOT WHILE <input type="checkbox"/> AT WORK | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>2/5/82</u> , 19 <u>82</u> , to <u>2/11</u> , 19 <u>82</u> , that (I) (we) last saw the deceased alive on <u>2/11</u> , 19 <u>82</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | |
| 22b. SIGNATURE
<u>Harvey Rosen MD</u> | | | | DEGREE
ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> | | 22c. DATE SIGNED
<u>2/11/82</u> | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
<u>Harvey Rosen</u> | | | | 22e. ADDRESS
<u>SINAI HOSP OF BALTIMORE</u> | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)
<u>Burial</u> | | 23b. DATE
<u>2-14-82</u> | | 23c. NAME OF CEMETERY OR CREMATORY
<u>Sharon Baptist Cemetery</u> | | 23d. LOCATION CITY OR TOWN COUNTY STATE
<u>Cockeville Howard Md.</u> | |
| 24. FUNERAL DIRECTOR NAME
<u>Harry W. Haight</u> | | | | ADDRESS
<u>Sylkesville, Md.</u> | | 25a. DATE REC'D. BY REGISTRAR
<u>FEB 6 1982</u> | |
| | | | | 25b. REGISTRAR'S SIGNATURE
<u>[Signature]</u> | | | |





TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL HOME. GIVE PAGE 4 TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 3 FOR THE FUNERAL HOME. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITH THE VITAL RECORDS, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

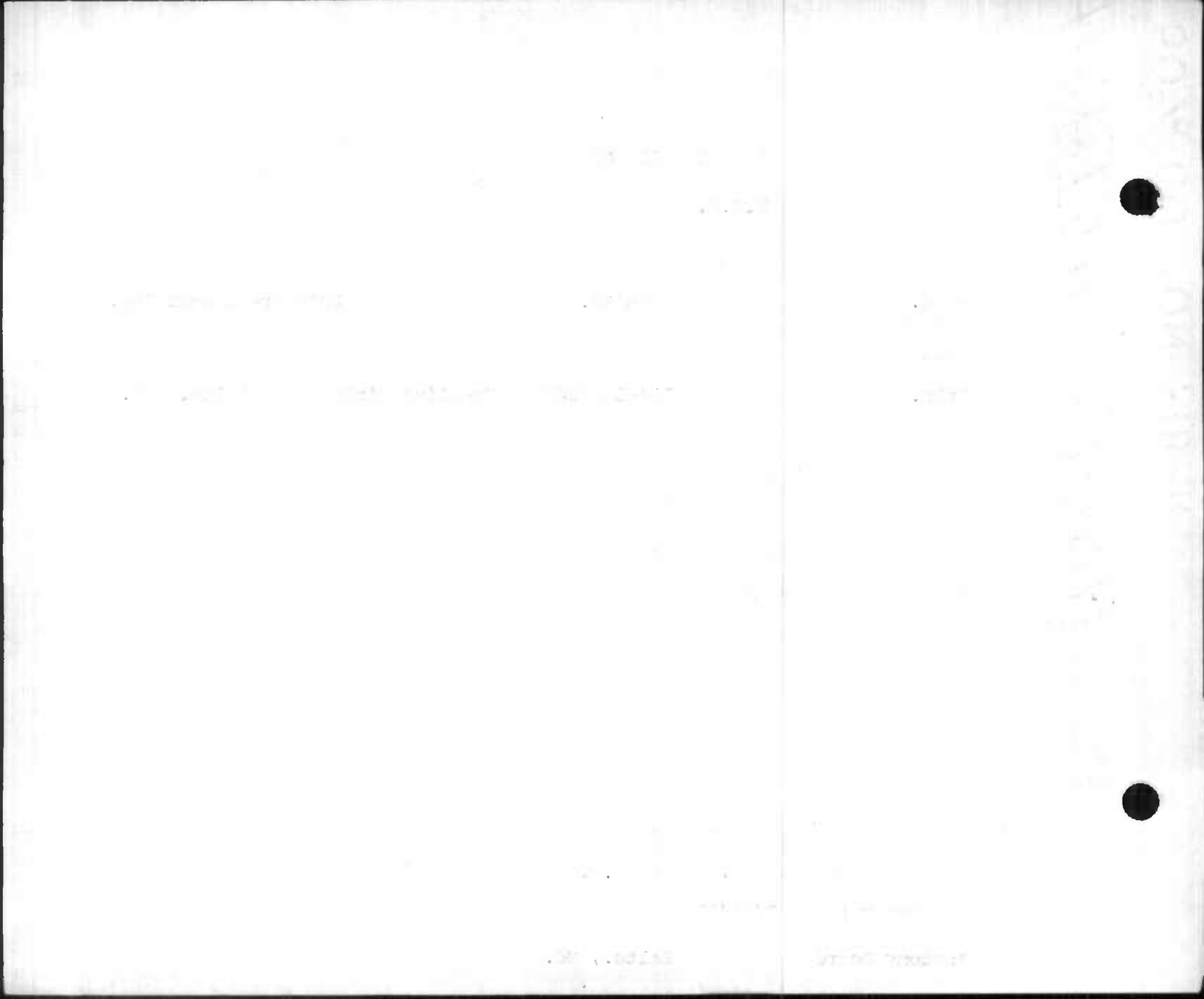
DHMH - 17
(VR A15 ME (5))
15M 2/80

| STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH | | | | | | | | | | REG. NO. 82 03672 | |
|--|--|------------------|--|---|--|--|--|---|--|---|--|
| 1. FOR REGISTRAR | | | | | | | | | | | |
| 1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST
Earl F Day | | | | | | | | | | 2a. DATE KNOWN OF DEATH ESTIMATED MONTH DAY YEAR
2-19-82 | |
| 3. SEX
male | | 4. RACE
white | | 5. DATE OF BIRTH MONTH DAY YEAR
2 2 20 | | 6. AGE (IN YEARS LAST BIRTHDAY) MONTHS DAYS HOURS MIN
62 YRS. | | IF UNDER 1 YR. IF UNDER 24 HRS. | | 2c. DATE PRONOUNCED DEAD MONTH DAY YEAR
2-19-82 | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
✓ | | | | 7b. CITIZEN OF WHAT COUNTRY?
U.S.A. | | | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
Baltimore City MD | |
| 10. CITY OR TOWN OF DEATH
Baltimore | | | | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
2930 Greenmount Avenue | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | | 12b. KIND OF BUSINESS OR INDUSTRY | |
| 13a. STATE
Md. | | 13b. COUNTY | | 13c. CITY OR TOWN
Balto. | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS
2930 Greenmount Ave. | | | |
| 14. FATHER'S NAME FIRST MIDDLE LAST | | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)
Unkn. | | | | 16b. SOCIAL SECURITY NO.
114-10-9263 | | 17. INFORMANT
Madeline Kirby | | ADDRESS
Balto., Md. | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I DEATH WAS CAUSED BY:
4292 IMMEDIATE CAUSE (a) Arteriosclerotic cardiovascular disease
Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.
(b) DUE TO, OR AS A CONSEQUENCE OF
(c) DUE TO, OR AS A CONSEQUENCE OF | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | | | | 20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH | | | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) | | | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/> | | | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | | | |
| 22a. I certify that I took charge of the remains described above, held on death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion | | | | | | | | | | | |
| ACTUAL SIGNATURE
Margarita A. Korell, M.D. | | | | TITLE (SPECIFY)
M.D. Assistant MEDICAL EXAMINER | | | | DATE SIGNED
2-19-82 | | | |
| EXAMINER'S NAME (TYPE OR PRINT)
Margarita A. Korell, M.D. | | | | ADDRESS
111 Penn Street | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)
Removal | | | | 23b. DATE
2/24/82 | | 23c. NAME OF CEMETERY OR CREMATORY | | 23d. LOCATION CITY OR TOWN COUNTY STATE | | | |
| 24. FUNERAL DIRECTOR NAME
Anatomy Board | | | | ADDRESS
Balto., Md. | | | | 25a. DATE REC'D. BY REGISTRAR
MAR 4 1982 | | 25b. REGISTRAR'S SIGNATURE
James J. [Signature] | |

MEDICAL CERTIFICATION

BP

1202



DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 2 0 3 6 7 3

1. FOR
STATE
REGISTRAR

REG. NO.

| | | | | | |
|---|--|---|--|--|--|
| 1. DECEASED NAME
(TYPE OR PRINT)
FIRST MIDDLE LAST
Robert L. Dayhoff | | | 2a. DATE OF DEATH
MONTH DAY YEAR
2 18 82 | | 2b. HOUR
1:00 PM |
| 3. SEX
Male | 4. RACE
White | 5. DATE OF BIRTH
MONTH DAY YEAR
April 16, 1952 | | 6. AGE (IN YEARS LAST BIRTHDAY)
29 YRS. | IF UNDER 1 YEAR
MONTHS DAYS
IF UNDER 24 HRS.
HOURS MIN. |
| 7. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
Maryland | 7b. CITIZEN OF WHAT COUNTRY?
U.S.A. | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
Baltimore City MD | |
| 10. CITY OR TOWN OF DEATH
Baltimore | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
StAGnes Hospital | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
Machinist Koppers Co. | | 12b. KIND OF BUSINESS OR INDUSTRY |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)
13a. STATE
Maryland | | | 13b. CITY OR TOWN
Woodlawn | | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
Bernard D. Dayhoff | | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
Ruth L | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
Yes | | 16b. SOCIAL SECURITY NO.
455 88 1901 | | 17. INFORMANT
ADDRESS
Mrs Mary Dayhoff 7400 LeSada Dr. 21207 | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART 1. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) 4310 Cardiac arrest.
DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.
(b) Hypotension
DUE TO, OR AS A CONSEQUENCE OF
(c) Intra-aortic atheroembolism & subarachnoid hemorrhage
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
1 day | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION, GIVEN IN PART 1: (a)
electrolyte imbalance & respiratory infection | | | | | |
| 19a. DATE OF OPERATION
2/18/82 | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED
electrolyte imbalance | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK AT WORK | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | |
| 22a. I certify that (a) (this hospital) attended the deceased from 1/11/82 to 2/18/82 , that (b) (we) last saw the deceased alive on 2/18/82 , and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (We) (did) (did not) view the body after death. | | | | | |
| 22b. SIGNATURE
Samim Chalabi | | DEGREE
ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> | | 22c. DATE SIGNED | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
SAMIM CHALABI | | 22e. ADDRESS | | | |
| 23a. BURIAL, CREMATION, REMOVAL
SPECIES
Burial | | 23b. DATE
Feb 22, 1982 | | 23c. NAME OF CEMETERY OR CREMATORY
Crestlawn | |
| 23d. LOCATION
CITY OR TOWN
Howard | | COUNTY
Maryland | | STATE | |
| 24. FUNERAL DIRECTOR
NAME
Harry H Witzke | | ADDRESS
4112 Columbia Rd Ellicott City | | 25a. DATE REC'D. BY REGISTRAR
FEB 19 1982 | |
| 25b. REGISTRAR'S SIGNATURE
James J. Nathan | | | | | |

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours of death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1 - FOR
STATE
REGISTRAR

DHMH - 16 50M 1/81
(VRA 15. 4)

Handwritten text, possibly a signature or name, located in the upper middle section of the page.

Handwritten text, possibly a date or a short phrase, located in the middle section of the page.

Large handwritten text block, possibly a signature or a name, located in the lower middle section of the page.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. It may be retained by the hospital or attending physician.

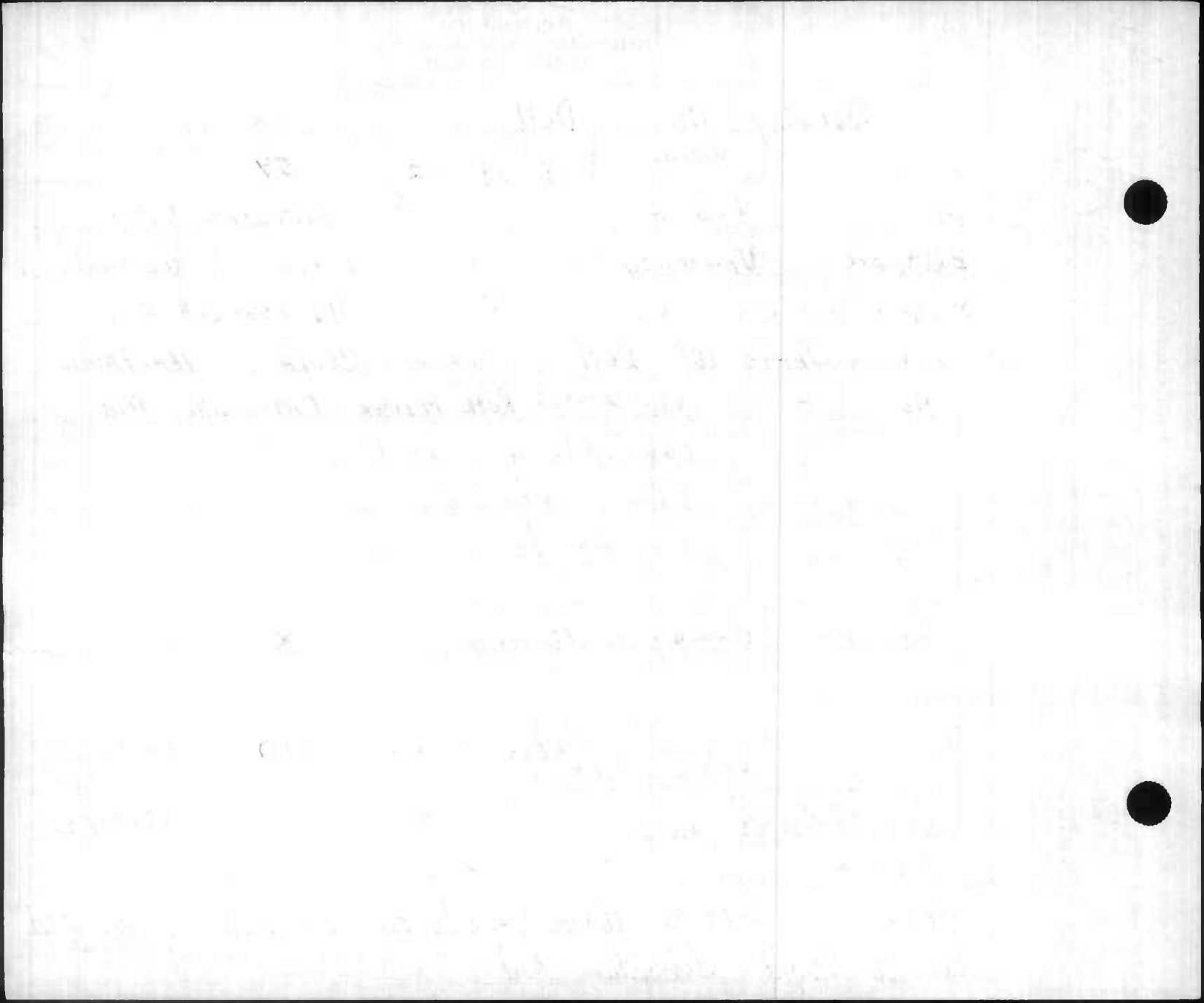
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 2 0 3 6 7 5

| | | | |
|--|--|---|--|
| 1. FOR STATE REGISTRAR | | REG. NO. | |
| 1. DECEASED NAME (TYPE OR PRINT) | | 2a. DATE OF DEATH | |
| FIRST MIDDLE LAST
Dorothy M. Dell | | MONTH DAY YEAR
02 17 82 | |
| 3. SEX | | 2b. HOUR | |
| Female | | 0610a | |
| 4. RACE | | 6. AGE (IN YEARS LAST BIRTHDAY) | |
| White-Caucasian | | 59 YRS | |
| 5. DATE OF BIRTH | | 7b. CITY OF WHAT COUNTRY? | |
| MONTH DAY YEAR
08 08 22 | | U.S.A. | |
| 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH | |
| 10. BIRTHPLACE (STATE OR FOREIGN COUNTRY) | | Baltimore City MD. | |
| Maryland | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | |
| 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) | | 12b. KIND OF BUSINESS OR INDUSTRY | |
| University Hospital | | Wire Westinghouse | |
| 13a. CITY OR TOWN OF DEATH | | 13b. STREET ADDRESS | |
| Baltimore | | 116 Stonewall Road | |
| 14. FATHER'S NAME | | 15. MOTHER'S MAIDEN NAME | |
| FIRST MIDDLE LAST
unknown James Wm Dell | | FIRST MIDDLE LAST
unknown Celia Hartman | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) | | 16b. SOCIAL SECURITY NO. | |
| No | | 216-20-043 | |
| 17. INFORMANT | | ADDRESS | |
| Ruth Farmer | | Catonsville, Md. | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| 4110 IMMEDIATE CAUSE (a) <u>cardiopulmonary arrest</u> | | | |
| DUE TO, OR AS A CONSEQUENCE OF | | | |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. | | | |
| (b) <u>heart failure</u> | | | |
| DUE TO, OR AS A CONSEQUENCE OF | | | |
| (c) <u>coronary artery bypass</u> | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | |
| 2/11/82 | | coronary insufficiency | |
| 20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? | |
| <input type="checkbox"/> | | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 21a. INJURY OCCURRED | | 21b. TIME OF INJURY | |
| WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | HOUR A.M. MONTH DAY YEAR
P.M. 19 | |
| 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | 21d. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | |
| | | 21e. LOCATION (STREET CITY OR TOWN COUNTY STATE) | |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>2/10</u> , 19 <u>82</u> , to <u>2/17</u> , 19 <u>82</u> , that (I) (we) lost saw the deceased alive on <u>2/17</u> , 19 <u>82</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | 22c. DATE SIGNED | |
| 22b. SIGNATURE | | 22d. ADDRESS | |
| Albert M. Laimon | | 225. Greene Street | |
| 22e. PHYSICIAN'S NAME (TYPE OR PRINT) | | 22f. ADDRESS | |
| Albert M. Laimon | | 225. Greene Street | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) | | 23b. DATE | |
| Burial | | 2-19-82 | |
| 23c. NAME OF CEMETERY OR CREMATORY | | 23d. LOCATION (CITY OR TOWN COUNTY STATE) | |
| Wards Chapel Cemetery | | Randalltown Balto. Md. | |
| 24. FUNERAL DIRECTOR NAME | | 25. DATE REC'D. BY REGISTRAR | |
| Harry W. Haight | | FEB 22 1982 | |
| ADDRESS | | REGISTER | |
| Sykesville, Md. | | James J. [Signature] | |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

3

1. FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 2 0 3 6 7 6

REG. NO.

| | | | | | | |
|---|--|---|--|--|--|---|
| 1. DECEASED NAME
(TYPE OR PRINT) MICHAEL E DEMETRIADES | | | 2a. DATE OF DEATH
MONTH 2 DAY 14 YEAR 1982 | | 2b. HOUR
9:30 AM | |
| 3. SEX
Male | 4. RACE
White | 5. DATE OF BIRTH
MONTH 11 DAY 8 YEAR 1900 | | 6. AGE (IN YEARS/ASST BIRTHDAY)
81 YRS. | | 7. UNDER 23 HRS.
MONTHS 0 DAYS 0 HRS. 0 MIN. |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
Greece | 7b. CITIZEN OF WHAT COUNTRY?
U.S.A | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
Baltimore City MD. | | |
| 10. CITY OR TOWN OF DEATH
Baltimore | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
St. Agnes Hospital | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
Waiter | | 12b. KIND OF BUSINESS OR INDUSTRY
Food | |
| 13a. STATE
Md. | | 13b. COUNTY
Baltimore | 13c. CITY OR TOWN
Baltimore | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | 13e. STREET ADDRESS
4700 Greenhill Avenue | |
| 14. FATHER'S NAME
FIRST Eftchies MIDDLE Demetriades LAST Demetriades | | | 15. MOTHER'S MAIDEN NAME
FIRST Unknown MIDDLE Unknown LAST Unknown | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
No | | 16b. SOCIAL SECURITY NO.
178-01-1414 | | 17. INFORMANT
Mrs. Litsa Demetriades
ADDRESS
4700 Greenhill Ave, Baltimore Md. | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART 1. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Probable Cardiac Arrhythmia
4100
DUE TO, OR AS A CONSEQUENCE OF
(b) Old & recent Myocardial infarction
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.
(c) Severe coronary atherosclerosis
DUE TO, OR AS A CONSEQUENCE OF
years | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
minutes | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)
myeloid metaplasia & osteosclerosis | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 2/12/82 19 to 2/14/82 19, that (I) (we) lost
saw the deceased alive on 2/14/82 19, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated
above, (I) (we) (did) (did not) view the body after death. | | | | | | |
| 22b. SIGNATURE
R. E. CRADLEY | | DEGREE
MD | | ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> | | 22c. DATE SIGNED
2/14/82 |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
R. E. CRADLEY | | | 22e. ADDRESS
ST AGNES HOSP. | | | |
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)
Burial | | 23b. DATE
2-16-82 | | 23c. NAME OF CEMETERY OR CREMATORY
Greek Orthodox Cem. | | 23d. LOCATION
CITY OR TOWN Baltimore COUNTY Baltimore STATE Md. |
| 24. FUNERAL DIRECTOR
NAME Nicholas T. Matthews ADDRESS 3024 Eastern Ave Baltimore, Md. | | | | 25a. DATE REC'D. BY REGISTRAR
FEB 17 1982 | | 25b. REGISTRAR'S SIGNATURE
Anna J. [Signature] |

Mr. J. H. ...
...
...

...
...
...

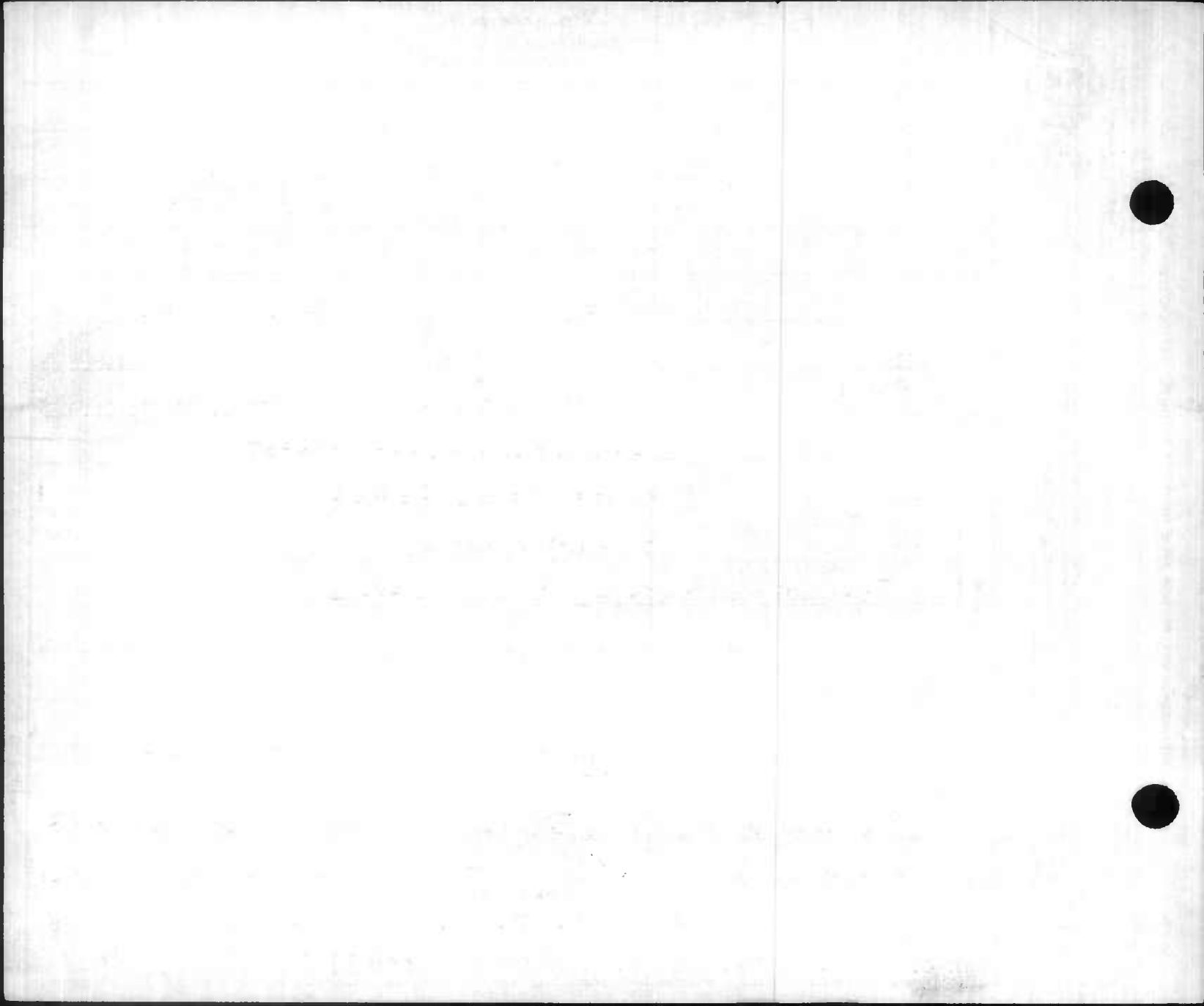
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.1. FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 2 0 3 6 7 7

REG. NO.

| | | | | | | | | | | | |
|--|--|--|---|--|--|---|--|--|--|--|--|
| 1. DECEASED NAME
(TYPE OR PRINT)
Silas | | | FIRST MIDDLE LAST
Desmond | | | 2a. DATE OF DEATH
MONTH DAY YEAR
February 10, 1982 | | | 2b. HOUR
M
 | | |
| 3. SEX
Male | | | 4. RACE
Black | | | 5. DATE OF BIRTH
MONTH DAY YEAR
3 19 20 | | | 6. AGE (IN YEARS LAST BIRTHDAY)
YRS
61 | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
MD | | | 7b. CITIZEN OF WHAT COUNTRY?
USA | | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | | 9. BALTIMORE CITY OR COUNTY OF DEATH
Baltimore City | | |
| 10. CITY OR TOWN OF DEATH
Baltimore | | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
914 E. Biddle St. | | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE) | | | 12b. KIND OF BUSINESS OR INDUSTRY | | |
| 13a. STATE
MD | | | 13b. COUNTY
 | | | 13c. CITY OR TOWN
Baltimore | | | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
Silas | | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
Emma Elliott | | | 13e. STREET ADDRESS
914 E. Biddle St. | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
Yes | | | 16b. SOCIAL SECURITY NO.
(IF YES, GIVE WAR OR DATES)
219-05-1696 | | | 17. INFORMANT
Evelyn Washington | | | ADDRESS
914 E. Biddle St. | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART 1. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) CARDIOPULMONARY ARREST
5908
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last:
(b) ACUTE RENAL FAILURE
(c) PYELONEPHRITIS | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a):
TORULOPSIS SEPSIS, E. coli SEPSIS | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
 P.M. 19 | | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | | | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/> | | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 12-4 19 81 , to 1-29 19 82 , that (I) (we) lost 1-29 19 82 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | | | |
| 22b. SIGNATURE
Dominick A. Curatola | | | | | | DEGREE
MD | | | 22c. DATE SIGNED
2-10-82 | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
Dominick A. Curatola | | | | | | 22e. ADDRESS
THE JOHNS HOPKINS HOSPITAL | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)
Burial | | | 23b. DATE
2/16/82 | | | 23c. NAME OF CEMETERY OR CREMATORY
MD. VET. CEM. | | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
Crownsville MD | | |
| 24. FUNERAL DIRECTOR
NAME
Wm. C. March F/H, Inc. | | | | | | ADDRESS
1101 E. North Avenue | | | 25a. DATE REC'D BY REGISTRAR
FEB 11 1982 | | |
| | | | | | | 25b. REGISTRAR'S SIGNATURE
James J. [Signature] | | | | | |

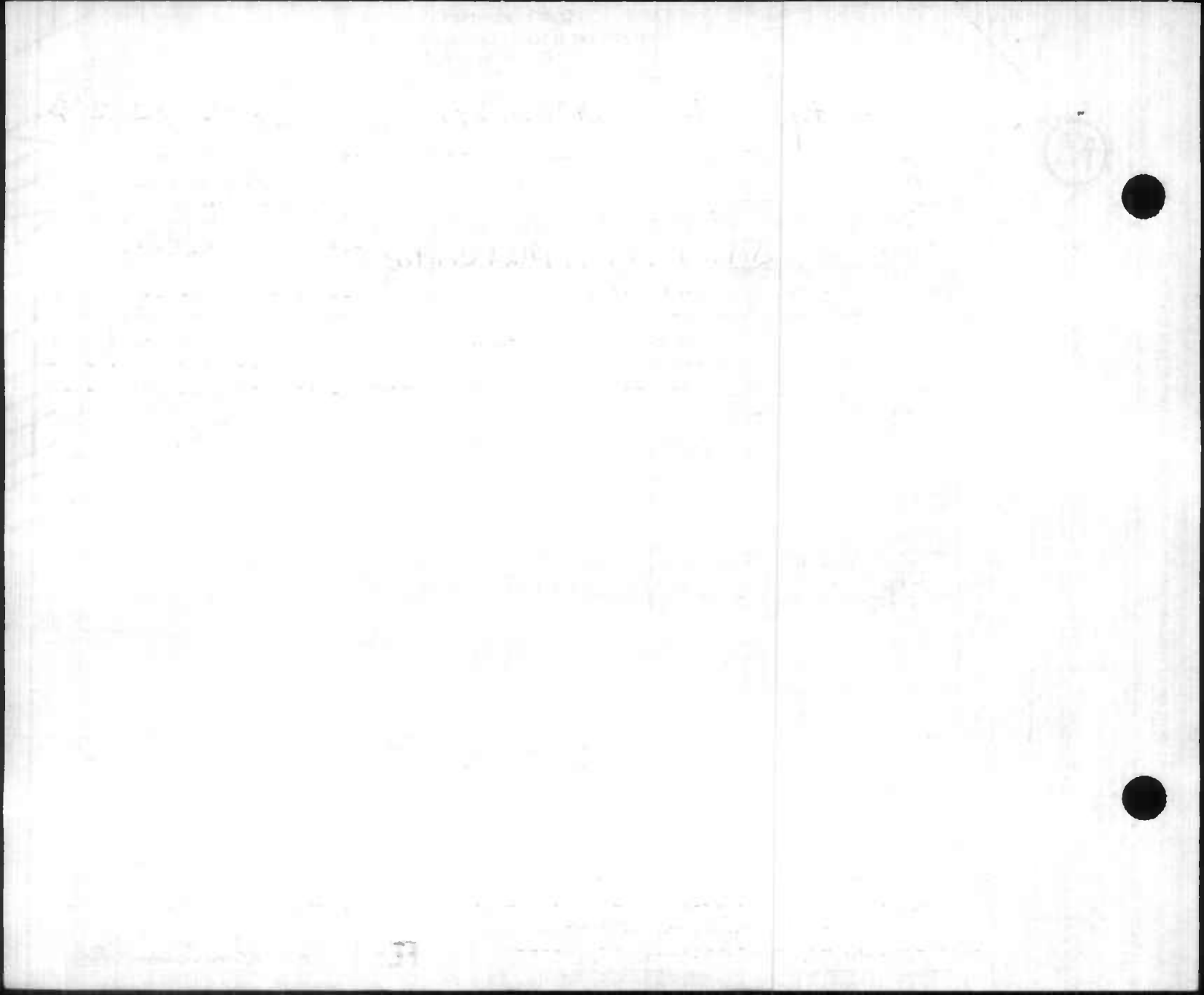


TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Populace may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

| STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH | | | | | | | | | |
|---|--|---|--|---|---|---|---|--|--|
| 1. DECEASED NAME
(TYPE OR PRINT) Betty L. DiClementi | | | | | 2a. DATE OF DEATH
MONTH DAY YEAR
2-16-82 | | 2b. HOUR
2:02 P. | | |
| 3. SEX
female | | 4. RACE
white | | 5. DATE OF BIRTH
MONTH DAY YEAR
May 21, 1923 | | 6. AGE (IN YEARS LAST BIRTHDAY)
YRS. MONTHS DAYS
58 | | IF UNDER 1 YEAR
IF UNDER 24 HRS. | |
| 7a. BIRTHPLACE
(STATE OR FOREIGN)
Penn. | | 7b. CITIZEN OF WHAT COUNTRY?
U.S.A. | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
Baltimore City MD. | | | |
| 10. CITY OR TOWN OF DEATH
Baltimore | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
John L. Deaton Med. Center | | | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
Cafeteria Worker | | 12b. KIND OF BUSINESS OR INDUSTRY
Schools | |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)
STATE COUNTY CITY OR TOWN
MD Balto. Hebbville | | | | | 13b. INSIDE CITY LIMITS?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 13c. STREET ADDRESS
7315 Windsor Mill Rd. | | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
Mac McGrane | | | | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
Lucy Ellis | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
No | | 16b. SOCIAL SECURITY NO.
(IF YES, GIVE WAR OR DATES)
217-16-7172 | | 17. INFORMANT
ADDRESS
Mr. Peter DiClementi Baltimore, Md. 21207 | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART 1. DEATH WAS CAUSED BY:
4360 PROBABLE MASSIVE CEREBROVASCULAR EVENT
DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last
(b) _____
DUE TO, OR AS A CONSEQUENCE OF
(c) _____ | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:
HISTORY of CEREBROVASCULAR ACCIDENT | | | | | | | | | |
| 19a. DATE OF OPERATION
FEB. 16 | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | | | |
| 21d. INJURY OCCURRED
WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from FEB. 5 , 19 82 , to FEB. 16 , 19 82 , that (I) (we) last saw the deceased alive on FEB. 16 , 19 82 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above (I) (we) (did) (did not) view the body after death. | | | | | | | | | |
| 22b. SIGNATURE
Winthrop C. Davis | | | | | DEGREE
PHYSICIAN | | 22c. DATE SIGNED
2/16/82 | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
DAVIS | | | | | 22e. ADDRESS
J.L. DEATON, BALTIMORE, MD. | | | | |
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)
Burial | | 23b. DATE
2/19/82 | | 23c. NAME OF CEMETERY OR CREMATORY
Lorraine Park Cem. | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
Woodlawn Balto. MD | | | |
| 24. FUNERAL DIRECTOR
NAME ADDRESS
Loring Byers Funeral Directors
8728 Liberty Rd. Randallstown, Md. 21133 | | | | | 25a. DATE REC'D. BY REGISTRAR
FEB 18 1982 | | 25b. REGISTRAR'S SIGNATURE
James J. [Signature] | | |



TO HOSPITAL OR ATTENDING PHYSICIAN. The law requires that the death certificate be executed within 24 hours after death. Page 4 must be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR. After this certificate has been signed by the attending physician and completely filled in by the funeral director, should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH | | | | | | | | | | 8 2 0 3 5 7 9 | |
|--|--|---|--|---|--|---|--|--|--|---------------|--|
| 1 - FOR
STATE
REGISTRAR | | REG. NO. | | | | | | | | | |
| 1. DECEASED NAME
(TYPE OR PRINT)
Mildred H. Diehl | | | | | | 2a. DATE OF DEATH
MONTH DAY YEAR
February 16, 1982 | | 2b. HOUR
900 AM | | | |
| 3. SEX
Female | | 4. RACE
White | | 5. DATE OF BIRTH
MONTH DAY YEAR
Dec. 18, 1914 | | 6. AGE (IN YEARS LAST BIRTHDAY)
67 YRS. | | IF UNDER 1 YEAR
MONTHS DAYS HOURS MIN. | | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
Maryland | | 7b. CITIZEN OF WHAT COUNTRY?
U.S.A. | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
Baltimore City MD. | | | | | |
| 10. CITY OR TOWN OF DEATH
Baltimore | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
6401 Loch Raven Blvd. (Residence) | | | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
Secretary | | 12b. KIND OF BUSINESS OR INDUSTRY | | | |
| 13a. STATE
Maryland | | 13b. COUNTY | | 13c. CITY OR TOWN
Baltimore | | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS
Balt., Md. 21239
6401 Loch Raven Blvd. | | | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
Edgar Henkelman | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
Elizabeth Thome | | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)
No | | | | | | | |
| 16b. SOCIAL SECURITY NO.
212-10-4060 | | 17. INFORMANT
Son: Jack Diehl Jr. | | | | ADDRESS
Balt., Md. 21239
1358 Walker Ave. | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART 1. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Massive myocardial infarction
4100
DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last:
(b) Hypertensive Cardiovascular Disease
DUE TO, OR AS A CONSEQUENCE OF
(c) Hyperlipidemia | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
1.5 minutes
1940
1974 | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: 0 | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | | | | | |
| 21d. INJURY OCCURRED
WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from April 7, 1970 to Feb 16, 1982 , that (I) (we) lost saw the deceased alive on Feb 16, 1982 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. If (we) (did) (did not) view the body after death. | | | | | | | | | | | |
| 22b. SIGNATURE
E. Alessi | | DEGREE
M.D. | | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | | | 22c. DATE SIGNED
2/17/82 | | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
Dr. Edward J. Alessi M.D. | | | | 22e. ADDRESS
6217 Harford Road Baltimore, Maryland | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)
Burial | | 23b. DATE
Feb 19 1982 | | 23c. NAME OF CEMETERY OR CREMATORY
New Cathedral Cem. | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
Baltimore Maryland | | | | | |
| 24. FUNERAL DIRECTOR
Leonard J. Ruck, Inc. Baltimore, Maryland | | | | 25a. DATE REC'D. BY REGISTRAR
FEB 18 1982 | | 25b. REGISTRAR'S SIGNATURE
Thomas J. Smith | | | | | |



Document 1, 1941

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STATE OF MARYLAND

DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 2 0 3 6 8 0

FOR
1. STATE
REGISTRAR

REG. NO.

| | | | | | |
|--|---|---|---|---|--|
| 1. DECEASED NAME
(TYPE OR PRINT)
MARIE M. DIETSCH | | | 2a. DATE OF DEATH
MONTH DAY YEAR
February 10, 1982 | | 2b. HOUR
M
M |
| 3. SEX
Female | 4. RACE
White | 5. DATE OF BIRTH
MONTH DAY YEAR
March 21, 1904 | | 6. AGE (IN YEARS LAST BIRTHDAY)
77 YRS.
IF UNDER 1 YEAR MONTHS DAYS
IF UNDER 24 HRS. HOURS MIN. | |
| 7. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
Maryland | 7b. CITIZEN OF WHAT COUNTRY?
United States | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
Baltimore City MD. | |
| 10. CITY OR TOWN OF DEATH
Baltimore | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
Baltimore City Hospital | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
House-wife | | 12b. KIND OF BUSINESS OR INDUSTRY
Home |
| 13a. STATE
Maryland | | | 13b. COUNTY
- - - | 13c. CITY OR TOWN
Baltimore | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
James - Zoch | | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
Rosalie - Ostrowski | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
NO | | | 16b. SOCIAL SECURITY NO.
(IF YES, GIVE WAR OR DATES)
212-74-4131 | | 17. INFORMANT
ADDRESS
George Dietsch 2336 Hamiltowne Cr. |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE is: Myocardial infarction
4100
DUE TO, OR AS A CONSEQUENCE OF
(b) Coronary artery disease
DUE TO, OR AS A CONSEQUENCE OF
(c) arteriosclerosis
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
Minutes | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (c) | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input type="checkbox"/> | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) | |
| 21d. INJURY OCCURRED
WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | |
| 22a. I certify that (I) (this hospital) attended the deceased from 19 77 to 2/10 19 82 , that (I) (we) lost saw the deceased alive on 2/9 19 82 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | |
| 22b. SIGNATURE
[Signature] | | DEGREE
MD
ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | 22c. DATE SIGNED
2/10/82 | |
| 22d. REGISTERIAN'S NAME (TYPE OR PRINT)
[Signature] | | 22e. ADDRESS
9 S. Highland Ave. | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)
Burial | | 23b. DATE
Feb. 13, 1982 | 23c. NAME OF CEMETERY OR CREMATORY
Sacred Heart of Jesus | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
- - Baltimore Co., Md. |
| 24. FUNERAL DIRECTOR
NAME
Lilly & Zeiler Inc. | | | 25a. DATE REC'D. BY REGISTRAR
FEB 16 1982 | | 25b. REGISTRAR'S SIGNATURE
[Signature] |

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DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

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1. FOR
STATE
REGISTRAR

REG. NO.

| | | | | | | | | | |
|---|--|---|---|---|--|---|--|--|--|
| 1. DECEASED NAME
(TYPE OR PRINT)
FIRST MIDDLE LAST
EARL DIGGS | | | 2a. DATE OF DEATH
MONTH DAY YEAR
FEB 22 1982 | | | 2b. HOUR
3⁰⁰ PM | | | |
| 3. SEX
MALE | | 4. RACE
NEGRO | | 5. DATE OF BIRTH
MONTH DAY YEAR
MAY 15 1908 | | 6. AGE (IN YEARS LAST BIRTHDAY)
73 YRS. | | IF UNDER 1 YEAR
MONTHS DAYS HOURS MIN. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
BALTO. Md. | | 7b. CITIZEN OF WHAT COUNTRY?
USA | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
BALTIMORE CITY MD | | | |
| 10. CITY OR TOWN OF DEATH
BALTO | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
SINAI HOSPITAL OF BALTO | | | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
MAINTENANCE | | 12b. KIND OF BUSINESS OR INDUSTRY
CITY OF BALTO. | |
| 13a. STATE
MARYLAND | | 13b. COUNTY | | 13c. CITY OR TOWN
BALTIMORE | | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS
3413 FOREST PARK AVE | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
HENRY JACKSON | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
ESTHER DIGGS | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
YES | | 16b. SOCIAL SECURITY NO.
217-071-531 | | 17. INFORMANT
ELIZABETH DIGGS | | ADDRESS
3413 FOREST PARK AVE. | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART 1. DEATH WAS CAUSED BY:
0389 SEPSIS - PNEUMONIA
IMMEDIATE CAUSE (a) _____
DUE TO, OR AS A CONSEQUENCE OF _____
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. _____
(b) _____
DUE TO, OR AS A CONSEQUENCE OF _____
(c) _____ | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:
UTI. | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | | | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK AT WORK | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>2-22</u> , 19 <u>82</u> , to <u>2-22</u> , 19 <u>82</u> , that (I) (we) last saw the deceased <u>on</u> <u>2-22</u> , 19 <u>82</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | |
| 22b. SIGNATURE
<i>[Signature]</i> | | | | DEGREE
ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | | | 22c. DATE SIGNED
2/22/82 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
D. LEBSON | | | | 22e. ADDRESS
3640 FORDS LANE | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)
BURIAL | | 23b. DATE
2-27-82 | | 23c. NAME OF CEMETERY OR CREMATORY
ARBUTHNOT CEMETERY | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
BALTO. Md | | | |
| 24. FUNERAL DIRECTOR
NAME ADDRESS
Isaiah W. Hayes 3112 Reisterstown Rd. | | | | 25a. DATE RECEIVED BY REGISTRAR
FEB 24 1982 | | 25b. REGISTRAR'S SIGNATURE
<i>[Signature]</i> | | | |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH | | | | | | | | | | | |
|---|--|--|--|---|--|--|--|--|--|--|--|
| 1. DECEASED NAME
(TYPE OR PRINT) SESSIE DIMITMAN | | | | | 2a. DATE OF DEATH
MONTH DAY YEAR 2-18-82 | | | | | 2b. HOUR
MIN 7:15 P | |
| 3. SEX
F FEMALE | | 4. RACE
W WHITE | | 5. DATE OF BIRTH
MONTH DAY YEAR 5 01 1895 | | 6. AGE (IN YEARS LAST BIRTHDAY)
86 YRS | | IF UNDER 1 YEAR
MONTHS DAYS | | IF UNDER 74 HRS
HOURS MIN | |
| 7a. BIRTHPLACE
(STATE OR FOREIGN COUNTRY) NEW YORK | | 7b. CITIZEN OF WHAT COUNTRY? US | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
BALTO. CITY MD. | | | | | |
| 10. CITY OR TOWN OF DEATH
MARYLAND | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) LEVINDALE | | | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE) BOOKKEEPER | | 12b. KIND OF BUSINESS OR INDUSTRY
LEO LAMM & CO. | | | |
| 13a. STATE
MD. | | 13b. CITY OR TOWN
BALTIMORE | | 13d. INSIDE CITY LIMITS?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 13e. STREET ADDRESS
2400 HUNT DRIVE 21209 | | | | | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
JACOB LEWIS | | | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
FANNIE UNKNOWN | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN) NO | | | | 16b. SOCIAL SECURITY NO.
072-20-4049 | | 17. INFORMANT MRS. ELEANOR BORIN | | | | 2400 HUNT DR. BALTO., MD 21209 | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART 1. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Cardiac failure
4289
DUE TO, OR AS A CONSEQUENCE OF
(b) _____
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO, OR AS A CONSEQUENCE OF
(c) _____
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
Days | | | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | | | |
| 21d. INJURY OCCURRED
WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 2/18 1982 to 2/18 1982 , that (I) (we) saw the deceased alive on above date(s) (did not) view the body after death. | | | | | | | | | | | |
| 22b. SIGNATURE
Steven A. Levenson | | | | 22c. DEGREE
MD | | | | 22d. DATE SIGNED
2/18/82 | | | |
| 22e. PHYSICIAN'S NAME (TYPE OR PRINT)
STEVEN A. LEVENSON, M.D. | | | | 22f. ADDRESS
LEVINDALE - BALTO., MD | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL
REMOVAL/BURIAL | | | | 23b. DATE
FEB. 19, 1982 | | 23c. NAME OF CEMETERY OR CREMATORY
OLD MONTEFIORE | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
ST ALBANS QUEENS NEW YORK | | | |
| 24. FUNERAL DIRECTOR SOL LEVINSON & BROS., INC.
NAME ADDRESS
6010 REISTERSTOWN RD. BALTO., MD 21215 | | | | | | 25a. DATE REC'D. BY REGISTRAR
FEB 24 1982 | | 25b. REGISTRAR'S SIGNATURE
<i>[Signature]</i> | | | |

MEDICAL CERTIFICATION

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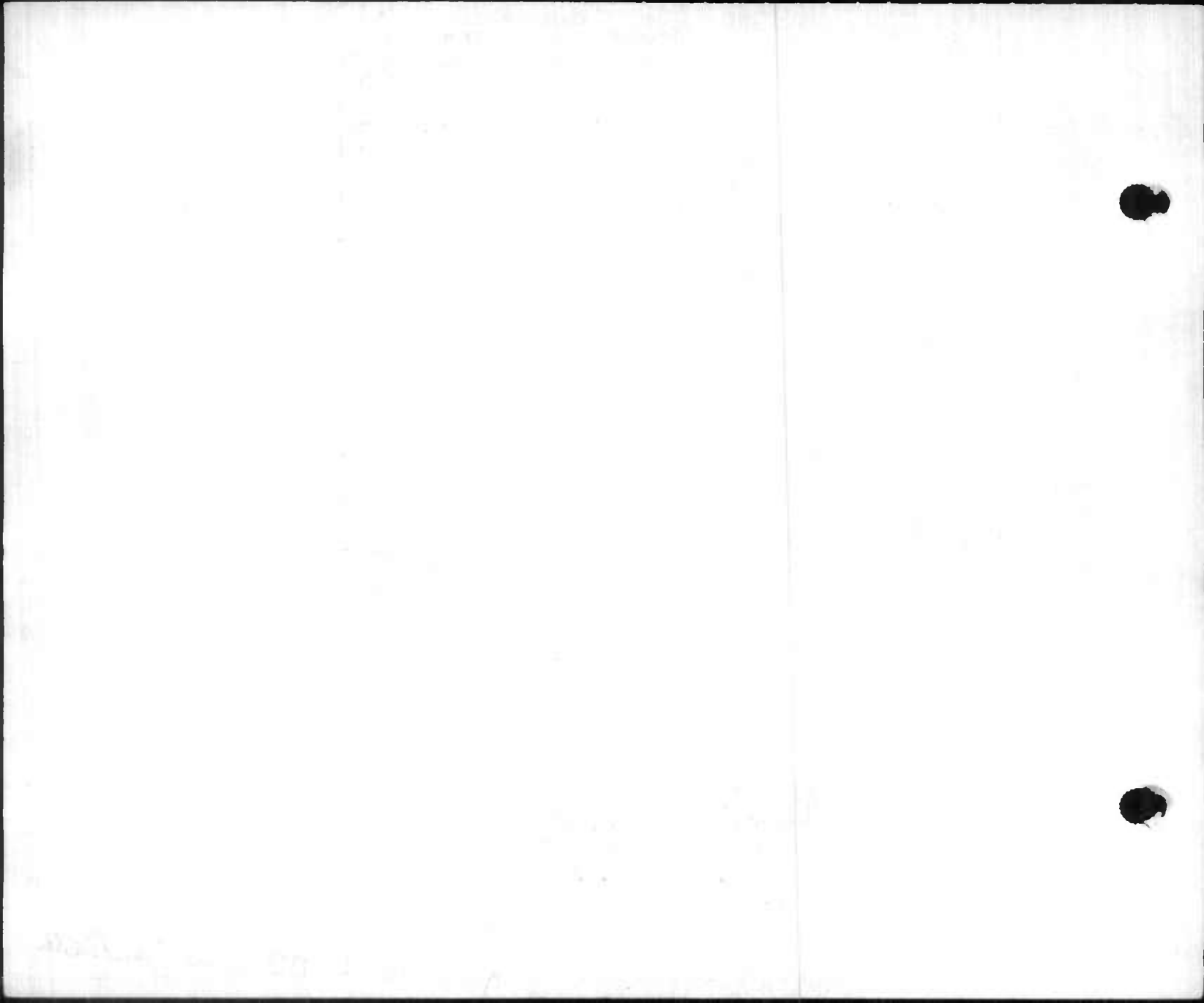
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10-10-10

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 24 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

| STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH | | | | | | | | | | REG. NO. 2 0 3 6 8 3 | |
|--|--|--|--|--|--|--|--|--|--|---|--|
| 1. FOR STATE REGISTRAR | | | | | | | | | | | |
| 1. DECEASED NAME (TYPE OR PRINT) JOSEPH J DiStefano | | | | | | | | | | 2a. DATE KNOWN OF DEATH 2-26-82 | |
| 3. SEX male 4. RACE white 5. DATE OF BIRTH Dec 16, 1911 6. AGE (IN YEARS) 70 7. IF UNDER 1 YR. 8. IF UNDER 24 HRS. | | | | | | | | | | 2b. DATE OF DEATH 2-26-82 19 | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland 7b. CITIZEN OF WHAT COUNTRY? U.S.A. 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | | | | | | | | | 2c. DATE PRONOUNCED DEAD 2-26-82 19 | |
| 10. CITY OR TOWN OF DEATH Baltimore 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 5902 Hillen road | | | | | | | | | | 9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City MD | |
| 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Retired Care Taker 12b. KIND OF BUSINESS OR INDUSTRY City Parks | | | | | | | | | | | |
| 13a. STATE Maryland 13b. COUNTY Baltimore 13c. CITY OR TOWN Baltimore 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> 13e. STREET ADDRESS 5902 Hillen Rd | | | | | | | | | | | |
| 14. FATHER'S NAME Albrico DiStefano 15. MOTHER'S MAIDEN NAME Carolyn Mili | | | | | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) No 16b. SOCIAL SECURITY NO. 216-01-5233 17. INFORMANT ADDRESS Mrs Vincenzina DiStefano Same | | | | | | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I DEATH WAS CAUSED BY:
9530 IMMEDIATE CAUSE (a) Hanging
DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause lost.
(b)
DUE TO, OR AS A CONSEQUENCE OF
(c)
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | | | | | | | | | | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I | | | | | | | | | | | |
| 19a. DATE OF OPERATION 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? 20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | | | | | | | | | |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH 21b. TIME OF INJURY Between 2-25 10:40AM 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2) subject hanged self | | | | | | | | | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input checked="" type="checkbox"/> 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) home 21f. LOCATION (STREET, CITY OR TOWN, COUNTY, STATE) 5902 Hillen Road Baltimore, Maryland | | | | | | | | | | | |
| 22a. I certify that I took charge of the remains described above, held on death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion | | | | | | | | | | | |
| ACTUAL SIGNATURE Margarita A. Korell TITLE (SPECIFY) Assistant MEDICAL EXAMINER DATE SIGNED 2-26-82 | | | | | | | | | | | |
| EXAMINER'S NAME (TYPE OR PRINT) Margarita A. Korell, M.D. ADDRESS 111 Penn Street | | | | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial 23b. DATE 3/1/82 23c. NAME OF CEMETERY OR CREMATORY Holy Redeemer 23d. LOCATION (CITY OR TOWN, COUNTY, STATE) Baltimore, Md | | | | | | | | | | | |
| 24. FUNERAL DIRECTOR NAME Leonard J Ruck Inc. Baltimore, Maryland ADDRESS 25a. DATE REC'D. BY REGISTRAR MAR 1 1982 25b. REGISTRAR'S SIGNATURE Francis J. Nathan | | | | | | | | | | | |



STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 2 0 3 6 8 4

1- FOR
STATE
REGISTRAR

REG. NO.

| | | | | | | | | | |
|---|--|--|--|--|--|---|---|--|--|
| 1. DECEASED NAME
(TYPE OR PRINT)
ANNIE M. DIVE | | | 2a. DATE OF DEATH
MONTH DAY YEAR
2 3 82 | | | 2b. HOUR
7:15 P.M. | | | |
| 3 SEX
Female | | 4 RACE
White | | 5. DATE OF BIRTH
MONTH DAY YEAR
10 - 1 - 11 | | 6 AGE (IN YEARS LAST BIRTHDAY)
70 YRS. | | 7. IF UNDER 1 YEAR
MONTHS DAYS HOURS MIN. | |
| 7a BIRTHPLACE (STATE OR FOREIGN COUNTRY)
MARYLAND | | 7b CITIZEN OF WHAT COUNTRY?
U.S.A. | | 8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/> | | 9 BALTIMORE CITY OR COUNTY OF DEATH
CITY MD. | | | |
| 10. CITY OR TOWN OF DEATH
Balt. | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN BALTIMORE CITY, GIVE STREET ADDRESS)
Mercy Hospital | | 12a USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
Sales | | 12b. KIND OF BUSINESS OR INDUSTRY
Dept. Store | | | |
| 13a STATE
Maryland | | 13b COUNTY
Baltimore | | 13c CITY OR TOWN
Baltimore | | 13d INSIDE CITY LIMITS?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 13e STREET ADDRESS
7601 Cypress Avenue | |
| 14 FATHER'S NAME
FIRST MIDDLE LAST
Ayler Stephens | | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
Agnes Crampton | | | 16a WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)
No | | | |
| 16b SOCIAL SECURITY NO.
232-26-7723 | | | 17. INFORMANT
Mary Gilbert | | | ADDRESS
7601 Cypress Ave.
Balto., MD. 21224 | | | |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART 1. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>Respiratory Arrest</u>
5990
DUE TO, OR AS A CONSEQUENCE OF, (b) <u>Sepsis</u>
DUE TO, OR AS A CONSEQUENCE OF, (c) <u>URINARY TRACT INFECTION</u>
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1
<u>CVA</u> | | | | | | | | | |
| 19a. DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/> | | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>2/1/82</u> to <u>2/3/82</u> , that (I) (we) last saw the deceased alive on <u>2/3/82</u> , and that (I) (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | |
| 22b. SIGNATURE
R.C. KUNZE | | | DEGREE
MD | | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | 3d. DATE SIGNED
2/5/82 | | |
| 22c. PHYSICIAN'S NAME (TYPE OR PRINT)
KUNZE | | | 22e. ADDRESS
Mercy Hosp. | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)
Burial | | | 23b. DATE
2/6/1982 | | 23c. NAME OF CEMETERY OR CREMATORY
Crestlawn | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
Marriottsville Maryland | | |
| 24 FUNERAL DIRECTOR
NAME
Duda-Ruck, Inc.
7922 Wise Avenue Dundalk, MD. 21222 | | | | | 25a. DATE REC'D. BY REGISTRAR
FEB 9 1982 | | 25b. REGISTRAR'S SIGNATURE
Thom... | | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be filed within 72 hours after death. Page 3 should be filed within 72 hours after death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified prior to burial, cremation, or removal.

MEDICAL CERTIFICATION

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STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 2 0 3 6 8 5

1- FOR
STATE
REGISTRAR

REG. NO.

| | | | | |
|--|--|---|---|---|
| 1. DECEASED NAME
(TYPE OR PRINT)
Willie Dixon | | 2a. DATE OF DEATH
MONTH DAY YEAR
2 21 82 | | 2b. HOUR
M |
| 3 SEX
male | 4. RACE
Black | 5. DATE OF BIRTH
MONTH DAY YEAR
01 17 43 | | 6. AGE (IN YEARS LAST BIRTHDAY)
39 YRS. |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
South Carolina | 7b. CITIZEN OF WHAT COUNTRY?
U.S.A. | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
Baltimore City MD. |
| 10. CITY OR TOWN OF DEATH
Balto. | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
THE JOHNS HOPKINS HOSPITAL | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
mechanic | 12b. KIND OF BUSINESS OR INDUSTRY
auto |
| 13a. STATE
MD. | | 13b. COUNTY
Balto. | 13c. CITY OR TOWN
Balto. | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
James Dixon | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
Mary Young | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
No | | 16b. SOCIAL SECURITY NO.
248-720154 | | 17. INFORMANT
ADDRESS
Annie Dixon 2607 W. North Ave. |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART 1. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Cardiomyopathy & cardiac arrest.
4254
DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last
(b) _____
DUE TO, OR AS A CONSEQUENCE OF
(c) _____ | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)
none | | | | |
| 19a. DATE OF OPERATION
— | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18. PART 1 OR PART 2) |
| 21d. INJURY OCCURRED
WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE |
| 22a. I certify that (I) (this hospital) attended the deceased from 2/18/82 to 2/21/82 19____, that (I) (we) last saw the deceased alive on 2/21/82 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | |
| 22b. SIGNATURE
J. Niles | | DEGREE
MD | | 22c. DATE SIGNED
2/21/82 |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
John L. Niles | | 22e. ADDRESS
Johns Hopkins Hospital. | | |
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)
Burial | 23b. DATE
2-28-82 | 23c. NAME OF CEMETERY OR CREMATORY
Family Cem. | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
Chaster. S. Carolina |
| 24. FUNERAL DIRECTOR
NAME
Carlton C. Douglas | | ADDRESS
669-1738
1012 Penn Ave. | | 25a. DATE REC'D. BY REGISTRAR
FEB 23 1982 |
| 25b. REGISTRAR'S SIGNATURE
James J. Mather | | | | |

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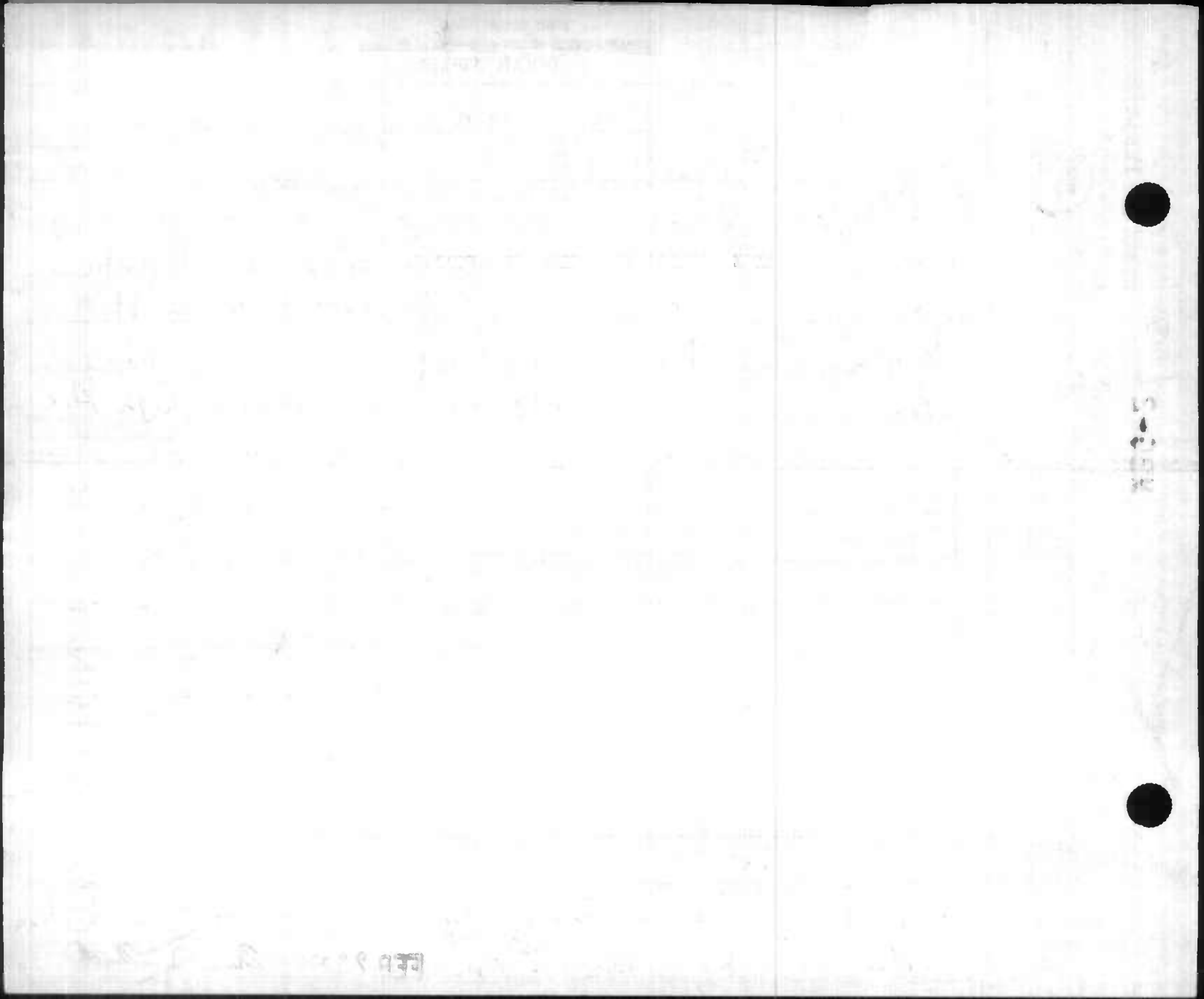
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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal with the State Dept. of Health and Mental Hygiene. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner may be notified.

1- FOR
STATE
REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 2 0 3 0 8 0

REG. NO.

| | | | | | | | | | |
|--|--|--|--|---|--|---|--|--|---|
| 1. DECEASED NAME
(TYPE OR PRINT)
FIRST MIDDLE LAST
MARY M. DOERING | | | 2a. DATE OF DEATH
MONTH DAY YEAR
2-23-1982 | | | 2b. HOUR
MIN
9 20 A M | | | |
| 3. SEX
F. | | 4. RACE
W | | 5. DATE OF BIRTH
MONTH DAY YEAR
8-30-1884 | | 6. AGE (IN YEARS LAST BIRTHDAY)
97 YRS. | | IF UNDER 1 YEAR
MONTHS DAYS
IF UNDER 24 HRS
HOURS MIN | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
MARYLAND | | 7b. CITIZEN OF WHAT COUNTRY?
U.S.A. | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
BALTIMORE CITY - MD. | | | |
| 10. CITY OR TOWN OF DEATH
BALTO. | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
723 N. MONTFORD AVE. | | | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
SEAMSTRESS | | 12b. KIND OF BUSINESS OR INDUSTRY
SEWING | |
| 13a. STATE
MD | | | 13b. COUNTY
- | | 13c. CITY OR TOWN
BALTO. | | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
CHARLES ELGERT | | | | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
CAROLINE WEBER | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
No | | | 16b. SOCIAL SECURITY NO.
216-01-5311 | | 17. INFORMANT
ADDRESS
Mrs. Mildred A. Matousek - 723 N. Montford Ave. | | | | |
| 18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c).
PART 1. DEATH WAS CAUSED BY
IMMEDIATE CAUSE (a) CEREBRAL VASCULAR ACCIDENT
4360
DUE TO, OR AS A CONSEQUENCE OF
(b) GENERALIZED ARTERIOSCLEROSIS
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.
DUE TO, OR AS A CONSEQUENCE OF
(c) _____ | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
24 HOURS | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (c) _____ | | | | | | | | | |
| 19a. DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK AT WORK | | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 2-23 , 19 82 , to 2-24 , 19 82 , that (I) (we) last saw the deceased alive on 2-23 , 19 82 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death. | | | | | | | | | |
| 22b. SIGNATURE
John J. Krejci | | | | | DEGREE
MD | | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | 22c. DATE SIGNED
2-24-82 |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
JOHN J. KREJCI | | | | | 22e. ADDRESS
1205 YORK RD LUTHERVILLE MD 21093 | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)
BURIAL | | | 23b. DATE
2-25-82 | | 23c. NAME OF CEMETERY OR CREMATORY
LOUDON PARK | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
BALTO. MD. | | |
| 24. FUNERAL DIRECTOR
NAME
Barbara Miller - 2334 | | | | | ADDRESS
Jefferson St. | | 25a. DATE REC'D. BY REGISTRAR
FEB 24 1982 | | 25b. REGISTRAR'S SIGNATURE
James J. [Signature] |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH | | | | 8 2 0 3 6 8 7
REG. NO. | | | |
|---|--|--|--|---|--|--|--|
| 1. DECEASED NAME
(TYPE OR PRINT)
FIRST MIDDLE LAST
Louise Douglas | | | | 2a. DATE OF DEATH
MONTH DAY YEAR
Feb 20 1982 | | 2b. HOUR
6³⁰ PM | |
| 3. SEX
F | | 4. RACE
B | | 5. DATE OF BIRTH
MONTH DAY YEAR
Jan 06 07 | | 6. AGE (IN YEARS LAST BIRTHDAY)
75 YRS | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
LA | | 7b. CITIZEN OF WHAT COUNTRY?
USA | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
City MD | |
| 10. CITY OR TOWN OF DEATH
Baltimore | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
Sinai Hosp. of Baltimore | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE) | | 12b. KIND OF BUSINESS OR INDUSTRY | |
| 13a. STATE
MD | | 13b. COUNTY
Baltimore | | 13c. CITY OR TOWN
Baltimore | | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
- - - | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
- - - | | 16. STREET ADDRESS
3800 W. Belvedere Ave. | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
NO | | 16b. SOCIAL SECURITY NO.
214-20-5046 | | 17. INFORMANT
ADDRESS
Melvin Williams Housing Authority | | | |
| 18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Intracerebral hemorrhage
4310
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.
DUE TO, OR AS A CONSEQUENCE OF (b) _____
DUE TO, OR AS A CONSEQUENCE OF (c) _____
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
1 1/2 months | | | | | | | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I
Synges, Hypertension | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) | | | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) lost
saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated
above, (I) (we) (did) (did not) view the body after death. | | | | | | | |
| 22b. SIGNATURE
Ming Chang | | DEGREE | | ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> | | 22c. DATE SIGNED
Feb. 20, 1982 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
MING CHANG | | 22e. ADDRESS
Sinai Hospital of Baltimore | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)
Burial | | 23b. DATE
2/24/82 | | 23c. NAME OF CEMETERY OR CREMATORY
Mt. Zion Cem. | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
Baltimore MD | |
| 24. FUNERAL DIRECTOR
NAME
Wm. C. March F/H 1101 E. North Ave. | | | | 25a. DATE REC'D. BY REGISTRAR
FEB 23 1982 | | | |
| | | | | 25b. REGISTRAR'S SIGNATURE
Thomas J. North | | | |



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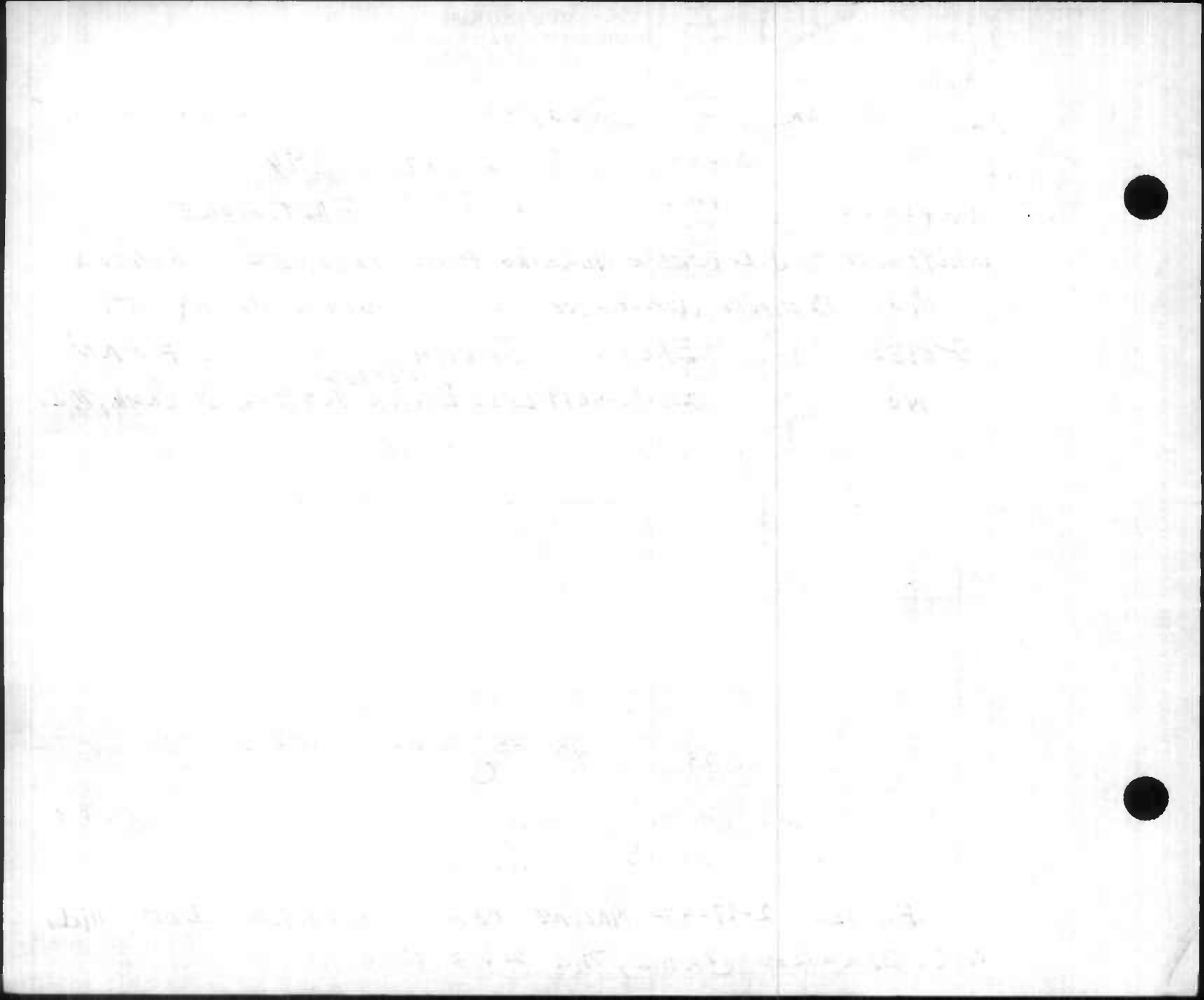
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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

| STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH | | | | | | | | | | 8 2 0 3 6 8 8 | |
|---|--|--|--|---|---|--|--|--|--|---------------|--|
| 1. FOR
STATE
REGISTRAR | | REG. NO. | | | | | | | | | |
| 1. DECEASED NAME
(TYPE OR PRINT) Susan Douglas | | | | | 2a. DATE OF DEATH
MONTH DAY YEAR
2 24 82 | | | 2b. HOUR
7:25 A | | | |
| 3. SEX
F | | 4. RACE
Black | | 5. DATE OF BIRTH
MONTH DAY YEAR
8 6 87 | | 6. AGE (IN YEARS LAST BIRTHDAY)
YRS. MONTHS DAYS
94 | | IF UNDER 1 YEAR
IF UNDER 24 HRS | | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
MARYLAND | | 7b. CITIZEN OF WHAT COUNTRY?
USA | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
BALTIMORE City MD | | | | | |
| 10. CITY OR TOWN OF DEATH
BALTIMORE | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
J.L. DEATON NURSING HOME | | | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
LABORER | | 12b. KIND OF BUSINESS OR INDUSTRY
RETIRED | | | |
| 13a. STATE
MD. | | 13b. COUNTY
BALTIMORE | | 13c. CITY OR TOWN
BALTIMORE | | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS
1517 N. CAREY ST. | | | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
STEVEN - BROWN | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
SARAH - TUBMAN | | | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
No | | 16b. SOCIAL SECURITY NO.
220-30-5099 | | 17. INFORMANT NEPHEW ADDRESS
LEON BROWN 709 HIGH ST. CAMB., MD. | | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) RESPIRATORY ARREST
7070
DUE TO, OR AS A CONSEQUENCE OF (b) SEPSIS
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last }
DUE TO, OR AS A CONSEQUENCE OF (c) MULTIPLE DECUBITUS ULCERS | | | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: (a)
GENERALIZED DEBILITATION | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) | | | | | | | |
| 21d. INJURY OCCURRED
WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from JAN. 28 , 19 82 , to FEB. 24 , 19 82 , that (I) (we) last saw the deceased alive on FEB. 23 , 19 82 , and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) not view the body after death. | | | | | | | | | | | |
| 22b. SIGNATURE
Winthrop C. Davis | | | | DEGREE
MD | | ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> | | 22c. DATE SIGNED
2/24/82 | | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
WINTHROP C. DAVIS | | | | 22e. ADDRESS
J.L. DEATON, 611 S. CHARLES, BALT., MD. | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)
BURIAL | | 23b. DATE
2-27-82 | | 23c. NAME OF CEMETERY OR CREMATORY
MALONE CEM. | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
MADISON DOR. MD. | | | | | |
| 24. FUNERAL DIRECTOR
NAME ADDRESS
L.H. Boardley CAMB., MD. 21613 | | | | 25a. DATE REC'D. BY REGISTRAR
MAR 3 1982 | | 25b. REGISTRAR'S SIGNATURE
<i>[Signature]</i> | | | | | |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP

DHMH-16 50M 1/81
(VRA 15, 4)

#5, per B.C. 7/9/82 kam

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

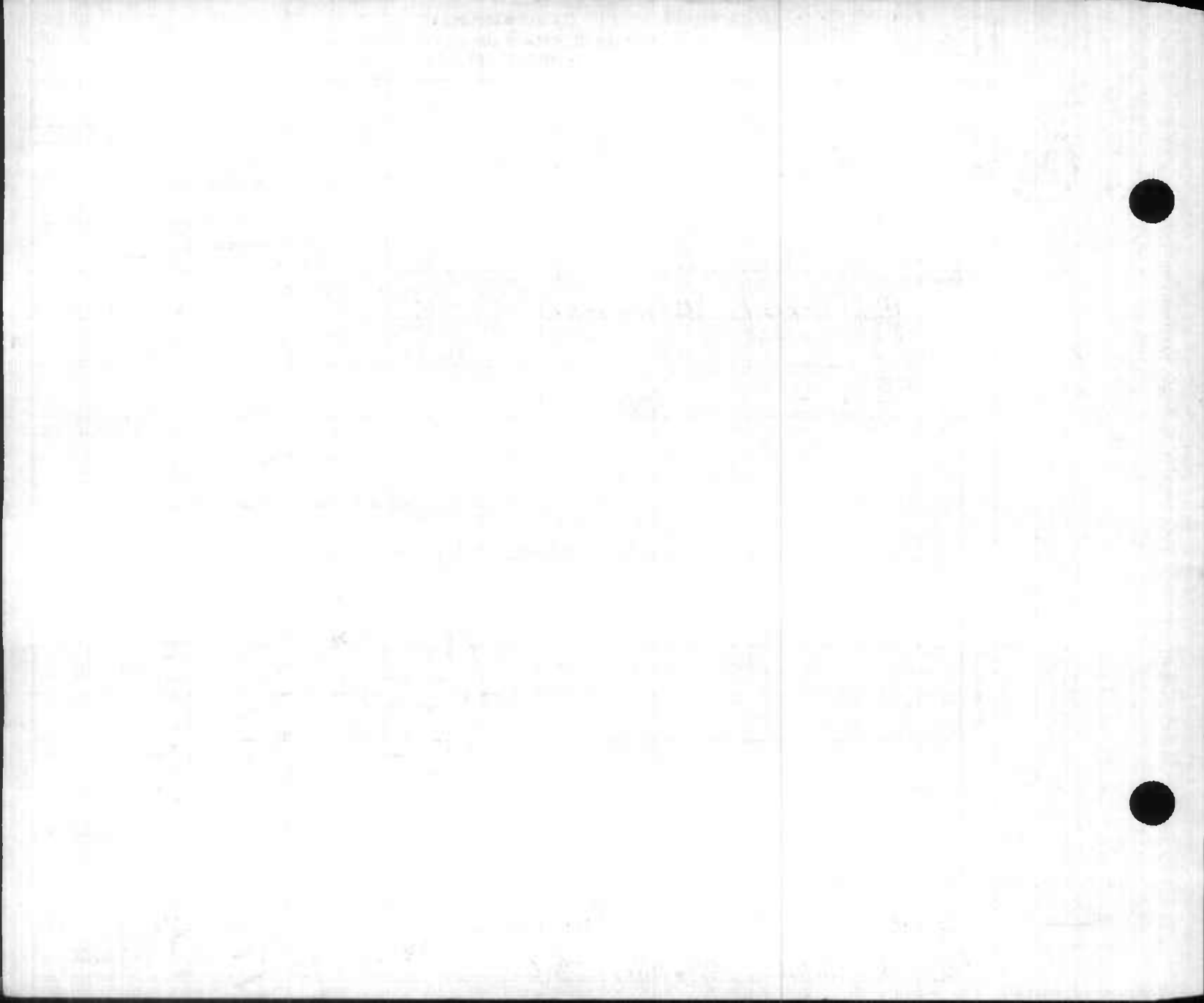
8 2 0 3 6 8 9

1- FOR
STATE
REGISTRAR

REG. NO.

| | | | | | |
|--|---|---|---|--|---|
| 1. DECEASED NAME
(TYPE OR PRINT)
Baby Girl (ANDREA) Dragoo | | | 2a. DATE OF DEATH
MONTH DAY YEAR
2 3 82 | | 2b. HOUR
15 A M |
| 3. SEX
male chromosome
phenotype female | 4. RACE
Caucasian | 5. DATE OF BIRTH
MONTH DAY YEAR
1 25 82 | | 6. AGE (IN YEARS LAST BIRTHDAY)
0 YRS 0 10 | |
| 7a. BIRTHPLACE
(STATE OR FOREIGN COUNTRY)
U.S.A. | 7b. CITIZEN OF WHAT COUNTRY?
U.S.A. | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
Baltimore City MD. | |
| 10. CITY OR TOWN OF DEATH
BALTIMORE | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
Univ. of Md Hospital | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
None | | 12b. KIND OF BUSINESS OR INDUSTRY
None |
| 13a. STATE
Md. | 13b. COUNTY
Westminster | 13c. CITY OR TOWN
Westminster | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | 13e. STREET ADDRESS
915 Klee mill rd, Westminster | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
ALLEN DRAGOO | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
Katherine CAMBER | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN) | | 16b. SOCIAL SECURITY NO.
None | | 17. INFORMANT
ADDRESS | |

| | | | | | |
|--|--|--|--|--|--|
| 18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c).
PART 1. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Cardio - Respiratory
7597
DUE TO, OR AS A CONSEQUENCE OF
(b) multiple congenital abnormalities including →
DUE TO, OR AS A CONSEQUENCE OF
(c) cardiac abnormality | | | | APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATH | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)
Gastrointestinal malabsorption - acute renal disorder | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 20b. IF YES, WERE FINDINGS USED
IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18. PART 1 OR PART 2) | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | |
| 22a. I certify that (I) (this hospital) attended the deceased from Jan 25, 19 82, to Feb 3, 19 82, that (I) (we) lost
saw the deceased alive on Feb 3, 19 82, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated
above, (I) (we) (did) (did not) view the body after death. | | | | | |
| 22b. SIGNATURE
Suzanne Laskas, M.D. | | | | 22c. DATE SIGNED
2/3/82 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
SUZANNE LASKAS | | | | 22e. ADDRESS
Univ. Md Hosp. Green Street. | |
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)
Burial | | 23b. DATE
2-5-82 | | 23c. NAME OF CEMETERY OR CREMATORY
Lake View Cemetery | |
| 23d. LOCATION
(CITY OR TOWN)
Sykesville | | 23e. COUNTY
Carroll | | 23f. STATE
Md | |
| 24. FUNERAL DIRECTOR
NAME
Harry W. Haight | | | | 25. DATE REC'D. BY REGISTRAR
FEB 9 1982 | |
| 26. REGISTRAR'S SIGNATURE
James J. [Signature] | | | | | |

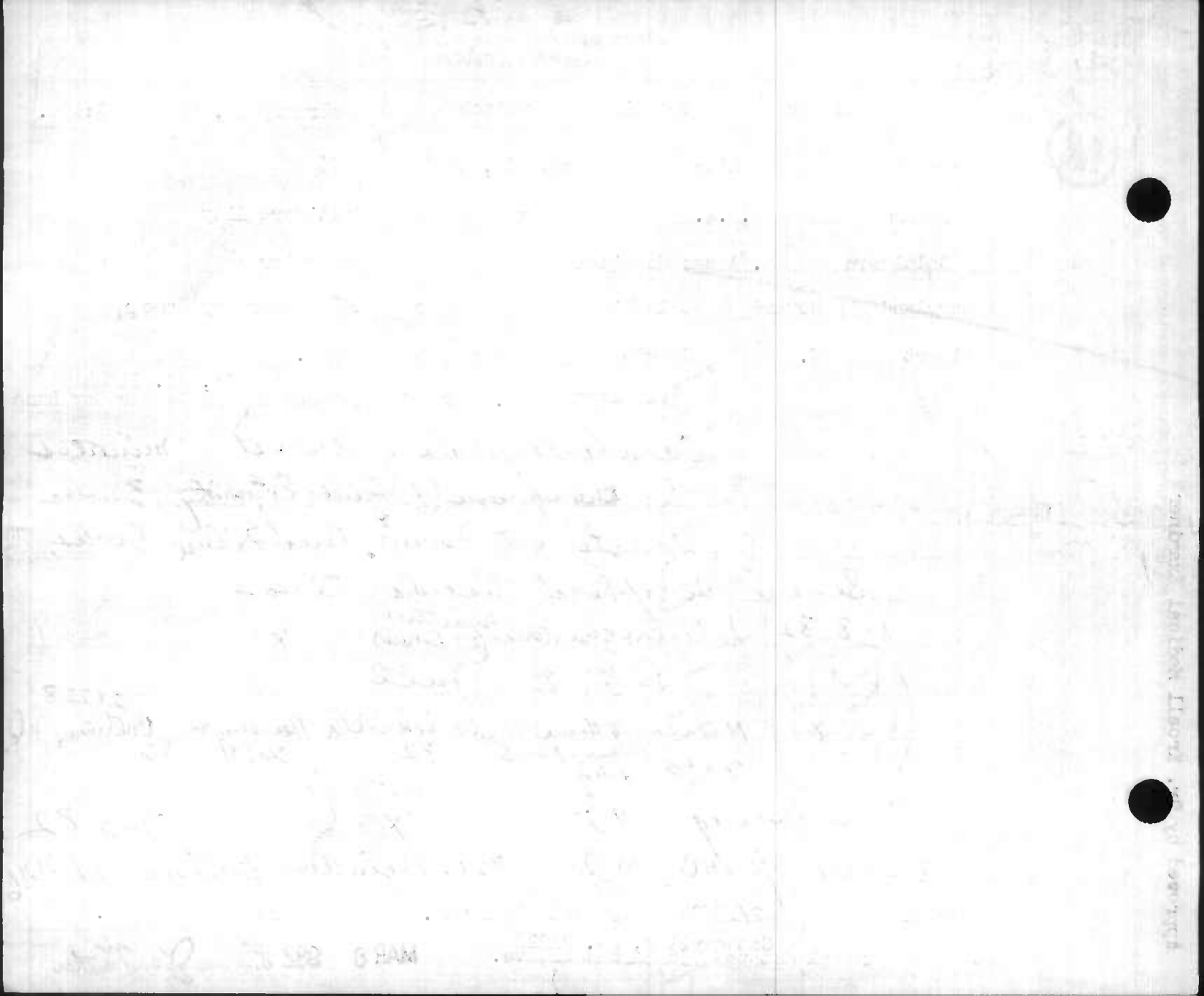


TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death, retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH | | | | 8 2 0 3 6 9 0 | | | | | |
|--|--|---|--|---|--|---|--|---|--|
| 1 - FOR
STATE
REGISTRAR | | | | REG. NO. | | | | | |
| 1. DECEASED NAME
(TYPE OR PRINT)
FIRST MIDDLE LAST
Florence Cecelia Dreisch | | | | 2a. DATE OF DEATH
MONTH DAY YEAR
February 13, 1982 | | | | 2b. HOUR
3:15A.M. | |
| 3. SEX
Female | | 4. RACE
White | | 5. DATE OF BIRTH
MONTH DAY YEAR
Feb, 20, 1905 | | 6. AGE (IN YEARS LAST BIRTHDAY)
76 YRS | | IF UNDER 1 YEAR
MONTHS DAYS
IF UNDER 24 HRS
HOURS MIN. | |
| 7a. BIRTHPLACE
(STATE OR FOREIGN
COUNTRY)
Maryland | | 7b. CITIZEN OF WHAT COUNTRY?
U.S.A. | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
Baltimore City MD. | | | |
| 10. CITY OR TOWN OF DEATH
Baltimore | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
St. Agnes Hospital | | | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
Homemaker | | 12b. KIND OF BUSINESS OR
INDUSTRY | |
| 13a. STATE
Maryland | | 13b. COUNTY
Howard | | 13c. CITY OR TOWN
Columbia | | 13d. INSIDE CITY LIMITS?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 13e. STREET ADDRESS
5058 Summer Day Lane | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
Albert T. Beavin | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
Anna L. ? | | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)
No | | | | | |
| 16b. SOCIAL SECURITY NO.
216-36-2578 | | | | 17. INFORMANT
Mrs. Patricia Lubbehasen 5058 Summer Day Lane | | | | ADDRESS
Columbia, Md. 21044 | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART 1. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Cardio-Respiratory Arrest
88880 DUE TO, OR AS A CONSEQUENCE OF
(b) Gangrene (L) Femur Extruded 3 wks
(c) Fracture (L) Femur, Renal Failure 5 wks.
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a.
Severe Peripheral Vascular Disease | | | | | | | | APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATH
minutes | |
| 19a. DATE OF OPERATION
1-8-82 | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED
Intertrochanteric Fracture (R) Femur | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED
IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | | |
| 21a. ACCIDENT WAS UNDERLYING
OR CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH
(IF EITHER NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 1-5 1982 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)
Fall | | 21d. INJURY OCCURRED
WHERE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/> | | | |
| 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)
Nursing Home Frederick Villa Nursing Home | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE
3200 Elgin Ave. Baltimore Md. 21228 | | 22a. I certify that (I) (this hospital) attended the deceased from 2-13-82 to 2-13-82, that (I) (we) last saw the deceased alive on 2-13-82, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | |
| 22b. SIGNATURE
Elroy Young, M.D. | | DEGREE
M.D. | | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | 22c. DATE SIGNED
3-5-82 | | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
ELROY YOUNG, M.D. | | 22e. ADDRESS
3200 Elgin Ave. Baltimore Md. 21228 | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)
Burial | | 23b. DATE
2/15/82 | | 23c. NAME OF CEMETERY OR CREMATORY
New Cathedral Cem. | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
Baltimore Md. | | | |
| 24. FUNERAL DIRECTOR
NAME
Sterling Funeral Estates 736 Edmondson Ave. | | | | 25a. DATE REC'D. BY REGISTRAR
MAR 8 1982 | | 25b. REGISTRAR'S SIGNATURE
Francis J. [Signature] | | | |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

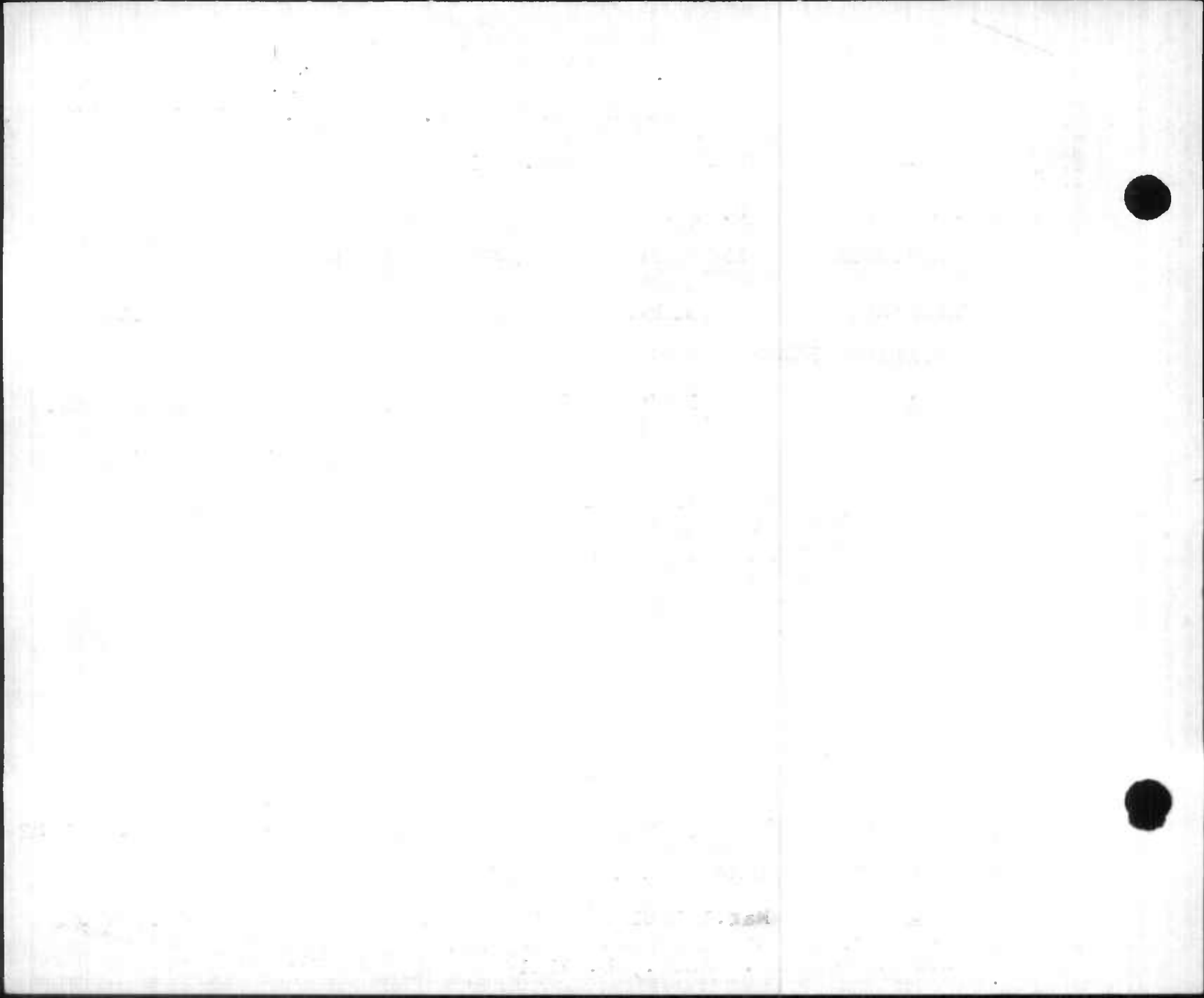
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of the death.

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 2 0 3 6 9 1

REG. NO.

| | | | | | |
|--|---|---|--|--|--|
| 1. DECEASED NAME
(TYPE OR PRINT)
FIRST MIDDLE LAST
WHARTON ALLEN DRURY, SR. | | | 2a. DATE OF DEATH
MONTH DAY YEAR
Feb. 26, 1982 | | 2b. HOUR
12:40P. |
| 3. SEX
MALE | 4. RACE
WHITE | 5. DATE OF BIRTH
MONTH DAY YEAR
Mar. 30, 1895 | | 6. AGE (IN YEARS LAST BIRTHDAY)
86 YRS.
IF UNDER 1 YEAR: MONTHS DAYS
IF UNDER 24 HRS: HOURS MIN. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
MARYLAND | 7b. CITIZEN OF WHAT COUNTRY?
U.S.A. | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
BALTIMORE CITY MD. | |
| 10. CITY OR TOWN OF DEATH
BALTIMORE | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
2906 KILDAIRE DRIVE | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
PRINTER | | 12b. EMPLOYER OR INDUSTRY
STIMPSON & DOLLER |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)
13a. STATE
MARYLAND | | | 13b. COUNTY
BALTIMORE | | 13c. CITY OR TOWN
BALTIMORE |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
WILLIAM DRURY DRURY | | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
FLORENCE ALLEN | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
WW 1 | | 16b. SOCIAL SECURITY NO.
(IF YES, GIVE WAR OR DATES)
212-07-0922 | | 17. INFORMANT
ADDRESS
MILDRED G. LEARD 2906 KILDAIRE DR. | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART 1. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>4149</u> Coronary artery disease
DUE TO, OR AS A CONSEQUENCE OF (b) _____
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO, OR AS A CONSEQUENCE OF (c) _____ | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
4 yrs. |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <u>Cerebral arteriosclerosis</u> | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK AT WORK | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>July 26, 1974</u> to <u>Feb 26, 1982</u> , that (I) (we) last saw the deceased alive on <u>Nov 7, 1981</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did not) view the body after death. | | | | | |
| 22b. SIGNATURE
Donald R. Jandorf | | DEGREE
M.D. | | 22c. DATE SIGNED
Feb. 27, 1982 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
DONALD R. JANDORF M.D. | | 22e. ADDRESS
7403 HARFORD ROAD | | | |
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)
BURIAL | | 23b. DATE
Mar. 1, 1982 | | 23c. NAME OF CEMETERY OR CREMATORY
GARDENS OF FAITH | |
| 23d. LOCATION
CITY OR TOWN COUNTY STATE
BALTO. MD. | | 23e. DATE REC'D. BY REGISTRAR
Mar 1 1982 | | | |
| 24. FUNERAL HOME OR ADDRESS
ROBERT C. ALTENBURG FUNERAL HOME, INC.
6009 HARFORD RD. BALTO., MD. 21214 | | | | | |



STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 2 0 3 6 9 2

1- FOR
STATE
REGISTRAR

REG. NO.

| | | | | | | | | | | |
|---|--|--|--|---|--|---|---|--|---|--|
| 1. DECEASED NAME
(TYPE OR PRINT)
Jarvis E. Dry Sr. | | | 2a. DATE OF DEATH
February 15, 1982 | | | 2b. HOUR
5:30P M | | | | |
| 3. SEX
male | | 4. RACE
Negro | | 5. DATE OF BIRTH
5 5 02 | | 6. AGE (IN YEARS LAST BIRTHDAY)
79 YRS. | | 7. IF UNDER 1 YEAR
MONTHS DAYS HOURS MIN. | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
North Carolina | | 7b. CITIZEN OF WHAT COUNTRY?
U.S.A | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
Baltimore City MD. | | | | |
| 10. CITY OR TOWN OF DEATH
Baltimore | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
Maryland General Hospital | | | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
Retired | | 12b. KIND OF BUSINESS OR INDUSTRY
1 | | |
| 13a. STATE
Md. | | | 13b. COUNTY
Baltimore | | 13c. CITY OR TOWN
Baltimore | | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS
501 Dolphin St. Apt. 914 | |
| 14. FATHER'S NAME
William Dry | | | 15. MOTHER'S MAIDEN NAME
Irene McNeal | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
NO | | | 16b. SOCIAL SECURITY NO.
213-01-4130 | | 17. INFORMANT
Ethel Donaldson 1102 Druid Hill Apt. 1001 | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART 1. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Hepatic Failure
5728
DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last
(b)
DUE TO, OR AS A CONSEQUENCE OF
(c) | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)
Poorly Differentiated Adenocarcinoma Metastases/ Etiology Unknown | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | | | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> OR WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> | | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from January 29, 1982, to February 15, 1982, that (we) last saw the deceased alive on February 15, 1982, and that in (we) (our) opinion death occurred on the date and hour and from the causes stated above. X (we) (did) (not) view the body after death. | | | | | | | | | | |
| 22b. SIGNATURE
Huang-Ta Lin, M.D. | | | DEGREE
M.D. | | | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> | | | 22c. DATE SIGNED
2/15/82 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
Huang-Ta Lin, M.D. | | | 22e. ADDRESS
c/o Maryland General Hospital | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL
Burial | | | 23b. DATE
2-19-82 | | 23c. NAME OF CEMETERY OR CREMATORY
Arbutus Mem Pk. | | 23d. LOCATION
Baltimore, Md. STATE | | | |
| 24. FUNERAL DIRECTOR
NAME
Calvin B. Scruggs Sr. | | | ADDRESS
1412 E. Preston St. | | | 25a. DATE REC'D. BY REGISTRAR
FEB 17 1982 | | 25b. REGISTRAR'S SIGNATURE
Thomas J. North | | |

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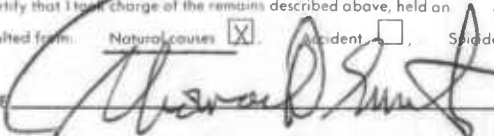
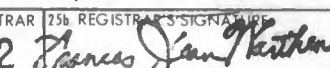
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TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 IN YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 48 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

DHMH - 17
(VR A15 ME (5))
15M 2/80

MEDICAL CERTIFICATION

| STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH | | | | | | | | | | REG. NO. 2 0 3 6 9 3 | |
|--|--|------------------|--|---|--|---|---|---|--|---|--|
| 1. DECEASED NAME
(TYPE OR PRINT) FIRST MIDDLE LAST
William B. Dukes | | | | | | | 2a. DATE KNOWN OF DEATH
ESTIMATED <input checked="" type="checkbox"/> MONTH DAY YEAR
2 23 1982 | | 2b. HOUR
M
a | | |
| 3. SEX
male | | 4. RACE
white | | 5. DATE OF BIRTH
MONTH DAY YEAR
10/1/03 | | 6. AGE (IN YEARS)
(LAST BIRTHDAY) YRS.
78 | | 7c. DATE PRONOUNCED DEAD
MONTH DAY YEAR
2 23 1982 | | 7d. HOUR
a M
8:17 | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
Baltimore | | | | 7b. CITIZEN OF WHAT COUNTRY?
USA | | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
Baltimore City MD. | | |
| 10. CITY OR TOWN OF DEATH
Baltimore | | | | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
620 N. Glover St. | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)
Clerk | | 12b. KIND OF BUSINESS OR INDUSTRY
Beth.Steel | |
| 13a. STATE
Md. | | 13b. COUNTY
- | | 13c. CITY OR TOWN
Balto. | | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS
620 N. Glover St. #21205 | | | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
Vincent William Dukes | | | | | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
Agatha Zadeckis | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO, OR UNKNOWN)
No | | | | 16b. SOCIAL SECURITY NO.
215-01-1069 | | 17. INFORMANT
ADDRESS
Mary K. Dukes, 620 N. Glover St. #21205 | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>Congestive heart failure</u>
4280
DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.
(b) _____
DUE TO, OR AS A CONSEQUENCE OF
(c) _____ | | | | | | | | | | | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a): | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | | | | | | 20. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH | | | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2) | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/> | | | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) | | | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> . | | | | | | | | | | | |
| ACTUAL SIGNATURE
 | | | | TITLE (SPECIFY)
M.D. Deputy Chief | | | | DATE SIGNED
2-23-82 | | | |
| EXAMINER'S NAME
(TYPE OR PRINT)
Thomas D. Smith, M.D. | | | | ADDRESS
111 Penn St. | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)
Burial | | | | 23b. DATE
2/26/82 | | 23c. NAME OF CEMETERY OR CREMATORY
Sacred Heart | | | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
Baltimore, Md. | |
| 24. FUNERAL DIRECTOR
Sodamunek Funeral Home, Inc.
3331 Brehms Lane, Baltimore, Maryland | | | | | | 25a. DATE REC'D. BY REGISTRAR
MAR 1 1982 | | 25b. REGISTRAR'S SIGNATURE
 | | | |

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Handwritten signature or mark, possibly "J. B. Smith", enclosed in a faint oval.

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 1b. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH. WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

FOR
1- STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | | | | | | | | |
|--|---------|------------------------------------|--|---|-------------------------------|--|--|---|---|--------------------------------------|--|------------------------------|--|--|
| 1. DECEASED NAME
(TYPE OR PRINT) | | | FIRST MIDDLE LAST | | | 2a. DATE KNOWN OF DEATH ESTIMATED | | | | 2b. HOUR | | | | |
| Laura V. Dunbar | | | | | | 2a. DATE KNOWN OF DEATH ESTIMATED
XX 2 6 19 82 | | | | 2b. HOUR
M | | | | |
| 3. SEX | 4. RACE | 5. DATE OF BIRTH
MONTH DAY YEAR | 6. AGE IN YEARS
(LAST BIRTHDAY) | IF UNDER 1 YR.
MONTHS DAYS | IF UNDER 24 HRS.
HOURS MIN | 2c. DATE PRONOUNCED DEAD | | | | 2d. HOUR | | | | |
| female | white | Jul 23, 1909 | 72 YRS. | | | 2c. DATE PRONOUNCED DEAD
2 8 19 82 | | | | 2d. HOUR
10:22 AM | | | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) | | | 7b. CITIZEN OF WHAT COUNTRY? | | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | | | 9. BALTIMORE CITY OR COUNTY OF DEATH | | | | |
| Maryland | | | U.S.A. | | | | | | | Baltimore City MD. | | | | |
| 10. CITY OR TOWN OF DEATH | | | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | | | | 12b. KIND OF BUSINESS OR INDUSTRY | | | | |
| Baltimore | | | 123 W. 29th Street | | | - | | | | - | | | | |
| USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) | | | | | | | | | | | | | | |
| 13a. STATE | | | 13b. COUNTY | | | 13c. CITY OR TOWN | | | 13d. INSIDE CITY LIMITS? | | | 13e. STREET ADDRESS | | |
| Maryland | | | - | | | Baltimore | | | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | 123 West 29th Street (21211) | | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST | | | | | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST | | | | | | | | |
| Bernard Dunbar | | | | | | unknown | | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO, OR UNKNOWN) | | | | 16b. SOCIAL SECURITY NO. | | | | 17. INFORMANT ADDRESS | | | | | | |
| No | | | | 218-34-0380 | | | | Ida Booz - 5603 Purdue Ave., (21239) | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Arteriosclerotic cardiovascular disease
4292 } DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. (b) }
DUE TO, OR AS A CONSEQUENCE OF (c) } | | | | | | | | | | | | | | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a). | | | | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | | | | 20. AUTOPSY? | | | | | | |
| | | | | | | | | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | | |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH | | | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) | | | | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK | | | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) | | | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | | | | |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> . | | | | | | | | | | | | | | |
| ACTUAL SIGNATURE | | | | | | TITLE (SPECIFY) | | | | | | | | |
| Thomas D. Smith, M.D. | | | | | | Deputy Chief MEDICAL EXAMINER | | | | | | | | |
| EXAMINER'S NAME (TYPE OR PRINT) | | | | | | ADDRESS | | | | | | | | |
| Thomas D. Smith, M.D. | | | | | | 111 Penn Street, Balto., MD 21201 | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) | | | | 23b. DATE | | | | 23c. NAME OF CEMETERY OR CREMATORY | | | | | | |
| Burial | | | | Feb 11, 1982 | | | | Druid Ridge Cemetery | | | | | | |
| 23d. LOCATION
CITY OR TOWN | | | | 23e. COUNTY | | | | 23f. STATE | | | | | | |
| Baltimore | | | | Maryland | | | | | | | | | | |
| 24. FUNERAL DIRECTOR | | | | | | 25a. DATE REC'D. BY REGISTRAR | | | | | | | | |
| A. Alan Seitz Funeral Home 3818 Roland Ave. | | | | | | FEB 10 1982 James J. Nathan | | | | | | | | |

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1000 2000 3000 4000 5000 6000 7000 8000 9000 10000

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. The low requires that the death certificate be executed within 24 hours after death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of cause.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 2 0 3 6 9 5

REG. NO.

| | | | | | |
|---|--|---|--|---|--|
| 1. DECEASED NAME
(TYPE OR PRINT)
THELMA J. DUNWOODY | | 2a. DATE OF DEATH
MONTH DAY YEAR
FEBRUARY 18, 1982 | | 2b. HOUR
11:25 A.M. | |
| 3. SEX
Female | 4. RACE
White | 5. DATE OF BIRTH
MONTH DAY YEAR
12 22 1907 | | 6. AGE (IN YEARS LAST BIRTHDAY)
74 YRS. | |
| 7a. BIRTHPLACE
(STATE OR FOREIGN COUNTRY)
New York | 7b. CITIZEN OF WHAT COUNTRY?
U.S.A. | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
Baltimore City MD. | |
| 10. CITY OR TOWN OF DEATH
Baltimore | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
Church Hospital Corporation | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
School Teacher | | 12b. KIND OF BUSINESS OR INDUSTRY
Balto., Co. |
| 13a. STATE
Maryland | | 13b. COUNTY
Baltimore | 13c. CITY OR TOWN
Dundalk | 13d. INSIDE CITY LIMITS?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
Lawrence Hume Julian | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
Mary Shields | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
No | | 16b. SOCIAL SECURITY NO.
214-38-3167 | | 17. INFORMANT
7008 ^{SS} Morningson Road
J. Harold Dunwoody Balto., MD. 21222 | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART 1. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>OAT CELL CARCINOMA LUNG</u>
1629
DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b) _____
DUE TO, OR AS A CONSEQUENCE OF
(c) _____ | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a):
_____ | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>FEBRUARY 13</u> , 19 <u>82</u> , to <u>FEBRUARY 18</u> , 19 <u>82</u> , that (I) (we) last saw the deceased alive on <u>FEBRUARY 18</u> , 19 <u>82</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | |
| 22b. SIGNATURE
<u>A. F. Nazemi</u> | | DEGREE
M.D. | | 22c. DATE SIGNED
<u>2/18/82</u> | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
A.F. NAZEMI, M.D. | | 22e. ADDRESS
CHURCH HOSPITAL CORPORATION
100 NORTH BROADWAY, BALTIMORE MD 21231 | | | |
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)
Burial | | 23b. DATE
2/22/1982 | | 23c. NAME OF CEMETERY OR CREMATORY
Fairview | |
| 23d. LOCATION
CITY OR TOWN COUNTY STATE
Coatsville Pa. | | | | | |
| 24. FUNERAL DIRECTOR
NAME
Duda-Ruck, Inc. | | ADDRESS
7922 Wise Avenue Dundalk, MD. 21222 | | 25a. DATE REC'D. BY REGISTRAR
FEB 22 1982 | |
| | | 25b. REGISTRAR'S SIGNATURE
<u>Frances Jan Nathan</u> | | | |

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

DHMH-16 50M 1/81
(VRA 15, 4)FOR
1- STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | | | |
|--|--|---|--|---|--|--|--|--|--|
| 1. DECEASED NAME
(TYPE OR PRINT) FIRST MIDDLE LAST
Evelyn J Durnant | | | 2a. DATE OF DEATH MONTH DAY YEAR
2-20-82 | | | 2b. HOUR MIN
9:00 AM | | | |
| 3. SEX
female | | 4. RACE
Black | | 5. DATE OF BIRTH MONTH DAY YEAR
8 6 18 | | 6. AGE (IN YEARS LAST BIRTHDAY) YRS.
63 | | IF UNDER 1 YEAR MONTHS DAYS
IF UNDER 24 HRS. HOURS MIN. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
Ind. | | 7b. CITIZEN OF WHAT COUNTRY?
United States | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
BALTIMORE CITY MD. | | | |
| 10. CITY OR TOWN OF DEATH
Baltimore | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
Baltimore Medical Center | | | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE) | | 12b. KIND OF BUSINESS OR INDUSTRY | |
| 13a. USUAL RESIDENCE (IF NOT IN SUCH FACILITY, GIVE RESIDENCE BEFORE ADMISSION)
13b. STATE
Ind. | | | | 13c. CITY OR TOWN
BALTIMORE | | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS
32 GARNET AVE. | |
| 14. FATHER'S NAME FIRST MIDDLE LAST
Preston Johnson | | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST
Elizabeth Johnson | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES NO OR UNKNOWN)
Unknown | | | | 16b. SOCIAL SECURITY NO.
(IF YES, GIVE WAR OR DATES)
214-16-089 | | 17. INFORMANT ADDRESS
Regina Aubrey 32 GARNET AVE. 01008 | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART 1. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) 1919 Brain tumor, malignant
DUE TO, OR AS A CONSEQUENCE OF (b)
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.
DUE TO, OR AS A CONSEQUENCE OF (c) | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
1 yr. | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) | | | | | | | | | |
| 19a. DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> | | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | | |
| 22a. I certify that (this hospital) attended the deceased from 12/23/81 to 2/18/82, that (we) last saw the deceased alive on 2/10/82, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (we) (did) (did not) view the body after death. | | | | | | | | | |
| 22b. SIGNATURE
J.P. Gladue M.D. | | | | | | DEGREE
ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | 22c. DATE SIGNED
2/22/82 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) | | | | | | 22e. ADDRESS | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)
Burial | | | 23b. DATE
2/25/82 | | 23c. NAME OF CEMETERY OR CREMATORY
Mt. Auburn Cem. | | 23d. LOCATION
Baltimore, Md. COUNTY STATE | | |
| 24. FUNERAL DIRECTOR
NAME
Leroy O. Dyett 4600 Liberty Heights Ave. | | | | | | 25a. DATE REC'D. BY REGISTRAR
FEB 23 1982 | | 25b. REGISTRAR'S SIGNATURE
Charles J. Walker | |

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the medical examiner, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.1- FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 2 0 3 6 9 7

REG. NO.

| | | | | | | | |
|---|--|--|---|---|--|--|--|
| 1. DECEASED NAME
(TYPE OR PRINT) MELVIN Clyde DUTTERER | | | 2a. DATE OF DEATH
MONTH DAY YEAR
2 26 82 | | | 2b. HOUR
MIN
10 0 | |
| 3. SEX
M | | 4. RACE
W | | 5. DATE OF BIRTH
MONTH DAY YEAR
6 14 06 | | 6. AGE (IN YEARS LAST BIRTHDAY)
75 | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
PENN | | 7b. CITIZEN OF WHAT COUNTRY?
USA | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
BALTIMORE CITY MD. | |
| 10. CITY OR TOWN OF DEATH
BALTIMORE | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
Mercy Hospital | | | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
ROAD COMM. | |
| 13a. STATE
MARYLAND | | 13b. COUNTY
BALTIMORE | | 13c. CITY OR TOWN
BALTO. HGLDS. | | 13d. INSIDE CITY LIMITS?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
CHARLES DUTTERER | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
PRUDENCE SHUEY | | 13e. STREET ADDRESS
3755 McDOWELL LANE, 21227 | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
NO | | 16b. SOCIAL SECURITY NO.
189-07-0050A | | 17. INFORMANT ADDRESS
Gloria Thomas 3755 McDowell Lane, 21227 | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART 1. DEATH WAS CAUSED BY:
1850 Melastasis Prostatic Carcinoma
IMMEDIATE CAUSE (a) _____
DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b) _____
DUE TO, OR AS A CONSEQUENCE OF
(c) _____ | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: _____ | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | |
| 21d. INJURY OCCURRED
WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 2/26 , 19 82 , to 2/26 , 19 82 , that (I) (we) last saw the deceased alive on 2/26 , 19 82 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death. | | | | | | | |
| 22b. SIGNATURE
<i>Frank J. Henderson</i> | | | | DEGREE
ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> | | 22c. DATE SIGNED
2/26/82 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
S. Henderson | | | | 22e. ADDRESS
Mercy Hospital BALTO MD. 21227 | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)
BURIAL | | 23b. DATE
03-02-82 | | 23c. NAME OF CEMETERY OR CREMATORY
REST HAVEN | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
HANOVER PA. | |
| 24. FUNERAL DIRECTOR
NAME ADDRESS
HUBBARD FUNERAL HOME, INC. 4107 WILKENS AVE. 21229 | | | | 25a. DATE REC'D. BY REGISTRAR
MAR 3 1982 | | | |

John D. Smith

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 2 0 3 6 9 8

REG. NO.

1. FOR
STATE
REGISTRAR

| | | | | | | | | | | |
|--|--|------------------|--|--|--|--|--|---|---|--|
| 1. DECEASED NAME
(TYPE OR PRINT)
James W. Dwyer | | | 2a. DATE OF DEATH
MONTH DAY YEAR
Feb. 15, 1982 | | | 2b. HOUR
M | | | | |
| 3. SEX
Male | | 4. RACE
White | | 5. DATE OF BIRTH
MONTH DAY YEAR
April 14, 1910 | | 6. AGE (IN YEARS LAST BIRTHDAY)
71 YRS. | | 7. IF UNDER 1 YEAR
MONTHS DAYS
IF UNDER 24 HRS
HOURS MIN. | | |
| 8. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
Maryland | | | 9. CITIZEN OF WHAT COUNTRY?
U.S.A. | | | 10. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | | 11. BALTIMORE CITY OR COUNTY OF DEATH
Baltimore City MD. | |
| 12. CITY OR TOWN OF DEATH
Baltimore | | | 13. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
South Balto. General Hospital | | | 14. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
Security Guard | | | 15. KIND OF BUSINESS OR INDUSTRY
Kenicott | |
| 16. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)
16a. STATE
Md. | | | 16b. COUNTY
Baltimore | | | 16c. CITY OR TOWN
Baltimore | | | 16d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 17. STREET ADDRESS
1413 Olmstead St. 21226 | | | 18. FATHER'S NAME
FIRST MIDDLE LAST
Joseph Dwyer | | | 19. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
Anna Mier | | | | |
| 20. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
No | | | 21. SOCIAL SECURITY NO.
213-20-9085 | | | 22. INFORMANT
Anna Huck 7937 Cross Creek Dr. Glen Burnie | | | 23. ADDRESS
21061 | |
| 24. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART 1. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>Acute Coronary Thrombosis</u>
4100
DUE TO, OR AS A CONSEQUENCE OF (b) <u>Atherosclerosis that caused</u>
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.
DUE TO, OR AS A CONSEQUENCE OF (c) | | | 25. APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) | | | | | | | | | | |
| 26. DATE OF OPERATION | | | 27. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 28. AUTOPSY?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | 29. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | |
| 30. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | | 31. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | | 32. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | | |
| 33. INJURY OCCURRED
WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK | | | 34. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)
11/18/82 | | | 35. LOCATION
STREET CITY OR TOWN COUNTY STATE
2141/82 | | | | |
| 36. I certify that (I) (this hospital) attended the deceased from 11/18/82, 19, to 2/14/82, 19, that (I) (we) lost saw the deceased alive on 2/14/82, 19, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | | |
| 37. SIGNATURE
<u>Alejandro Montoya, M.D.</u> | | | 38. DEGREE
ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | | 39. DATE SIGNED | | | | |
| 40. PHYSICIAN'S NAME (TYPE OR PRINT)
Alejandro Montoya, MD | | | 41. ADDRESS
7845 Oakwood Road Glen Burnie, Md. | | | | | | | |
| 42. BURIAL, CREMATION, REMOVAL
(SPECIFY)
Burial | | | 43. DATE
2/18/82 | | 44. NAME OF CEMETERY OR CREMATORY
Cedar Hill Cemetery | | 45. LOCATION
CITY OR TOWN COUNTY STATE
Baltimore Md. | | | |
| 46. FUNERAL DIRECTOR
NAME
George J. Gonce Funeral Home 4001 Ritchie Hwy. | | | 47. BALTO. MD. ADDRESS
21225 | | 48. DATE REC'D. BY REGISTRAR
FEB 19 1982 | | 49. REGISTRAR'S SIGNATURE
Frances Van Natter | | | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 10 days after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

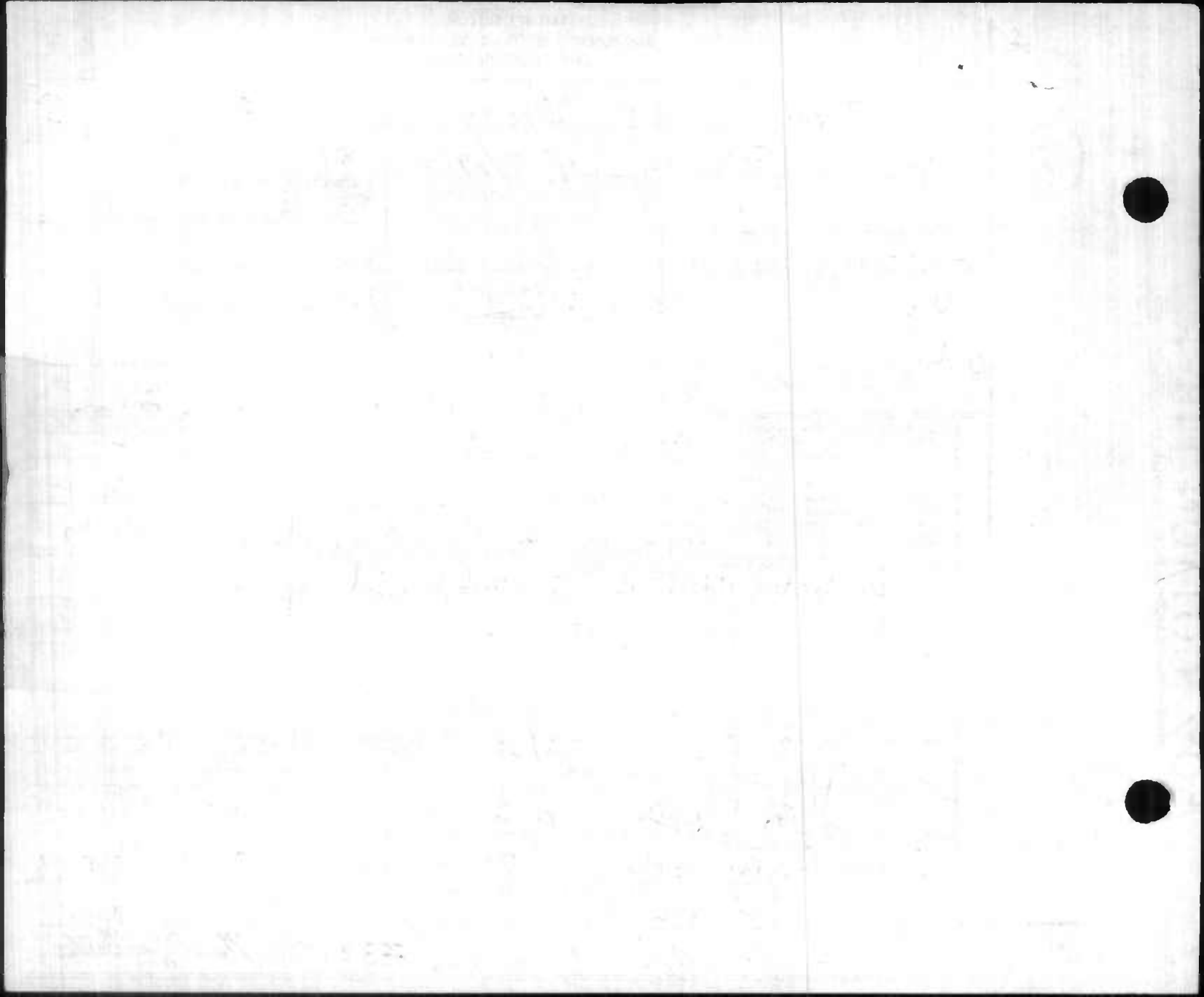
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

| STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH | | | | | | | | | | REG. NO. 8203099 | |
|---|--|--|--|---|--|---|--|--|--|------------------|--|
| 1. DECEASED NAME
(TYPE OR PRINT) Jacob Dyson | | | | | | 2a. DATE OF DEATH
MONTH DAY YEAR
2-19-82 | | 2b. HOUR
3¹⁵ PM | | | |
| 3. SEX
Male | | 4. RACE
Black | | 5. DATE OF BIRTH
YEAR
7/7/1900 | | 6. AGE (IN YEARS LAST BIRTHDAY)
81 | | IF UNDER 1 YEAR
MONTHS DAYS HOURS MIN.
YRS. | | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
Baltimore | | 7b. CITIZEN OF WHAT COUNTRY?
U.S.A. | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
Baltimore City MD | | | | | |
| 10. CITY OR TOWN OF DEATH
Baltimore | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
Lutheran Hospital of Md. | | | | 12a. USUAL OCCUPATION
(TYPE OR WORK FOR MOST OF WORKING LIFE)
Retired | | 12b. KIND OF BUSINESS OR INDUSTRY | | | |
| 13a. STATE
Md. | | 13b. COUNTY
Smith. Co. | | 13c. CITY OR TOWN
Baltimore | | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS
190 W. Lombard St. | | | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
unk. | | | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
unk. | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN) | | | | 16b. SOCIAL SECURITY NO.
218-10-3799 | | 17. INFORMANT
ADDRESS
W. Lombard Square Nursing Home | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART 1. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Cardiac arrest
DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b) Acidosis
(c) Renal failure. Respiratory failure
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
2 hr.
2 wks. | | | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a):
Diabetes Mellitus. Intraabdominal sepsis. | | | | | | | | | | | |
| 19a. DATE OF OPERATION
2/18/82 | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED
Pneumocystis pneumonia | | | | 20a. AUTOPSY
YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | | | | | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> AT WORK
AT HOME <input type="checkbox"/> AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 2/18 19 82 to 2/19 19 82 , that (I) (we) last saw the deceased alive on 2/19 19 82 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did not) view the body after death. | | | | | | | | | | | |
| 22b. SIGNATURE
Juan Arrisueno | | | | DEGREE
M.D. | | ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | 22c. DATE SIGNED
2/19/82 | | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
JUAN ARRISUENO | | | | 22e. ADDRESS
730 Ashburton St. Baltimore | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL
Burial | | 23b. DATE
2/24/82 | | 23c. NAME OF CEMETERY OR CREMATORY
Mt. Calvary | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
AA County MD | | | | | |
| 24. FUNERAL DIRECTOR
NAME
Samuel | | | | ADDRESS
1712 W. North Ave | | 25. DATE REC'D. BY REGISTRAR
FEB 23 1982 | | 25a. REGISTRAR'S SIGNATURE
Thomas J. [Signature] | | | |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 should be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours of death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH | | | | | | | | | |
|---|--|--|--|--|--|--|--|--|--|
| 1. FOR STATE REGISTRAR | | | | | | | | | |
| 1 DECEASED NAME
(TYPE OR PRINT)
THOMAS WAYNE EARP | | | | | 2a. DATE OF DEATH
MONTH DAY YEAR
2-19-82 | | | | |
| 3 SEX
Male | | | | | 4 RACE
White | | | | |
| 5. DATE OF BIRTH
MONTH DAY YEAR
Jan. 7, 1921 | | | | | 6 AGE (IN YEARS LAST BIRTHDAY)
61 YRS | | | | |
| 7a BIRTHPLACE (STATE OR FOREIGN COUNTRY)
Maryland | | | | | 7b CITIZEN OF WHAT COUNTRY?
USA | | | | |
| 8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | | | | 9 BALTIMORE CITY OR COUNTY OF DEATH
Baltimore City MD | | | | |
| 10 CITY OR TOWN OF DEATH
Baltimore | | | | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
Good Samaritan Hospital | | | | |
| 12a USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
Messenger | | | | | 12b KIND OF BUSINESS OR INDUSTRY
Couriers | | | | |
| 13a STATE
Maryland | | | | | 13b COUNTY | | | | |
| 13c CITY OR TOWN
Baltimore | | | | | 13d INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | | |
| 13e STREET ADDRESS
823 E. Lake Avenue | | | | | | | | | |
| 14 FATHER'S NAME
FIRST MIDDLE LAST
Stephen Earp | | | | | 15 MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
Lenna Erler | | | | |
| 16a WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)
Yes WW II | | | | | 16b SOCIAL SECURITY NO.
214 18 1069 | | | | |
| 17. INFORMANT
Mrs. Kathryn Earp | | | | | ADDRESS
Same | | | | |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>Acute Myocardial Infarction</u>
4100
DUE TO, OR AS A CONSEQUENCE OF
(b) <u>Cardiogenic Shock</u>
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last
(c) _____ | | | | | | | | | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1
19a DATE OF OPERATION | | | | | | | | | |
| 19b CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | | | | | | |
| 20a AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | | | | | |
| 20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | | | | | | | | |
| 21a ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | | | | | | |
| 21b TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | | | | | | | | |
| 21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) | | | | | | | | | |
| 21d INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK AT WORK | | | | | | | | | |
| 21e PLACE OF INJURY
(AT HOME STREET FACTORY OFFICE FARM, ETC.) | | | | | | | | | |
| 21f LOCATION
STREET CITY OR TOWN COUNTY STATE | | | | | | | | | |
| 22a I certify that (1) (this hospital) attended the deceased from <u>2/19</u> 19 <u>82</u> to <u>2/19</u> 19 <u>82</u> , that (we) last saw the deceased alive on <u>2/19</u> 19 <u>82</u> , and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (If we) (did not) view the body after death. | | | | | | | | | |
| 22b SIGNATURE
<u>M. N. KHAN</u> DEGREE <u>MD</u> | | | | | | | | | |
| 22c DATE SIGNED
<u>2-19-82</u> | | | | | | | | | |
| 22d PHYSICIAN'S NAME (TYPE OR PRINT)
<u>M. N. KHAN</u> | | | | | | | | | |
| 22e ADDRESS
<u>5601 - Loch Raven Blvd. Balto. MD 21239</u> | | | | | | | | | |
| 23a BURIAL, CREMATION, REMOVAL (SPECIFY)
<u>Burial</u> | | | | | | | | | |
| 23b DATE
<u>2/22/82</u> | | | | | | | | | |
| 23c NAME OF CEMETERY OR CREMATORY
<u>Parkwood</u> | | | | | | | | | |
| 23d LOCATION
CITY OR TOWN COUNTY STATE
<u>Balto. Co., Md.</u> | | | | | | | | | |
| 24 FUNERAL DIRECTOR
NAME ADDRESS
<u>Henry W. Jenkins & Sons Co.</u>
<u>4905 York Road Balto., Md. 21212</u> | | | | | | | | | |
| 25a. DATE REC'D. BY REGISTRAR
<u>FEB 22 1982</u> | | | | | | | | | |
| 25b REGISTRAR'S SIGNATURE
<u>[Signature]</u> | | | | | | | | | |

THURSDAY 10/12/85

10/12/85

U

Good morning to all

<

Good

11/11/85

11/11/85

11/11/85

FEB 25 1985

1-15

1-15

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the health department after death.

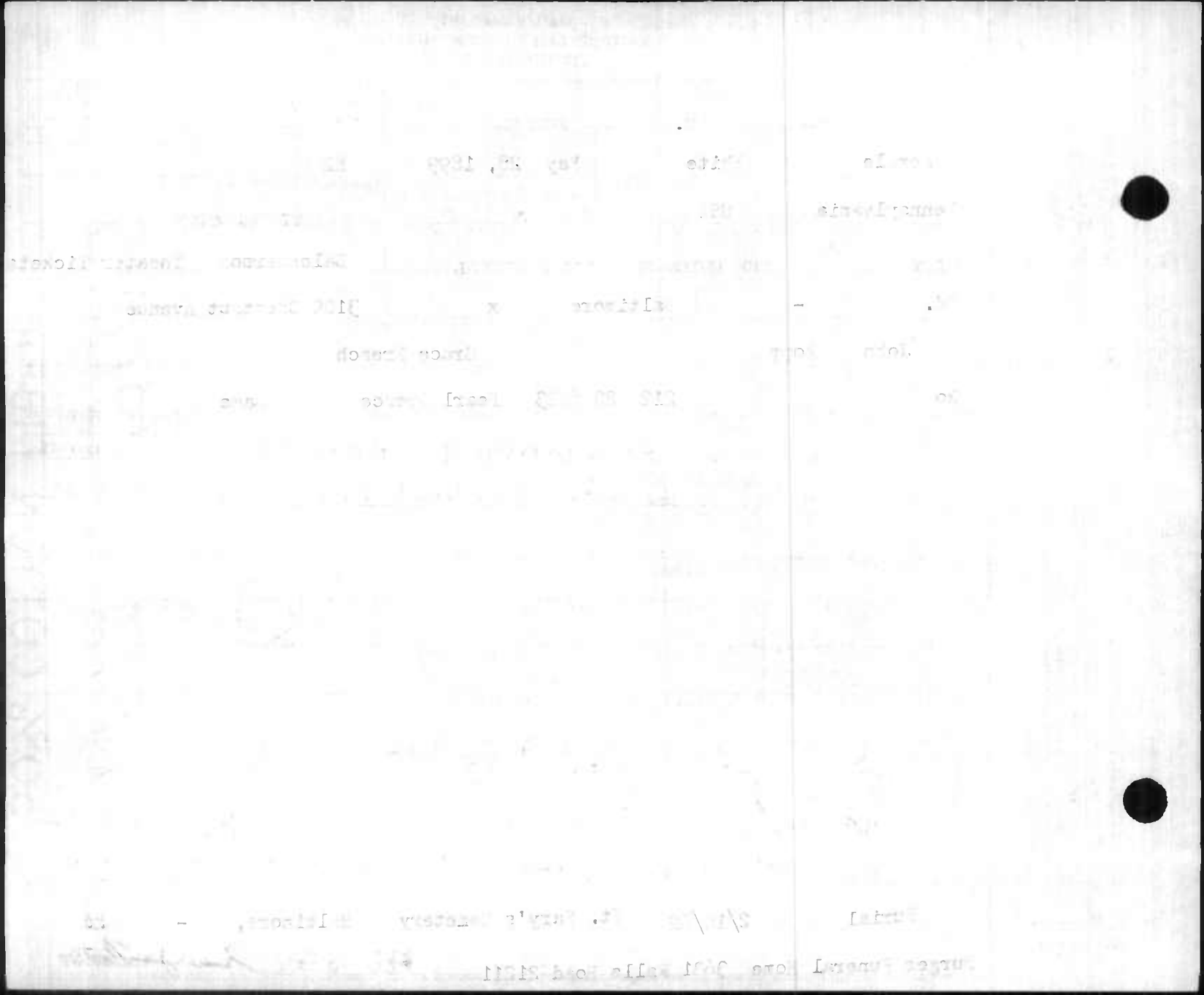
IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical certificate must be submitted as required.

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

8 2 0 3 7 0 1

| | | | | | | |
|---|--|---|--|---|-----------------------------|---|
| 1. DECEASED NAME
(TYPE OR PRINT)
FIRST MIDDLE LAST
EMMA T. ECKERL | | | 2a. DATE OF DEATH
MONTH DAY YEAR
2-8-82 | | 2b. HOUR
12:15 AM | |
| 3. SEX
Female | | 4. RACE
White | | 5. DATE OF BIRTH
MONTH DAY YEAR
May 28, 1899 | | 6. AGE (IN YEARS LAST BIRTHDAY)
82 YRS. |
| 7. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
Pennsylvania | | 7b. CITIZEN OF WHAT COUNTRY?
USA | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
BALTIMORE CITY MD. |
| 10. CITY OR TOWN OF DEATH
CITY | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
THE UNION MEMORIAL HOSPITAL | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
Salesperson | | 12b. KIND OF BUSINESS OR INDUSTRY
Theater Tickets |
| 13. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)
13a. STATE Md. 13b. COUNTY - 13c. CITY OR TOWN Baltimore 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> 13e. STREET ADDRESS 3109 Chestnut Avenue | | | | | | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
John kopp | | | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
Grace French | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(NO OR UNKNOWN) No (IF YES, GIVE WAR OR DATES) | | 16b. SOCIAL SECURITY NO.
212 20 6023 | | 17. INFORMANT
ADDRESS
Pearl Spence Same | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART 1. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) RESPIRATORY ARREST
4310 DUE TO, OR AS A CONSEQUENCE OF
(b) intracerebral hemorrhage
DUE TO, OR AS A CONSEQUENCE OF
(c) 2-3-82 | | | | | | APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATH
IMMEDIATE |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED
IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | |
| 22a. I certify that (1) (this hospital) attended the deceased from 2-4 , 19 82 , to 2-8 , 19 82 , that (1) (we) lost
saw the deceased alive on 2-7 , 19 82 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated
above, (1) (we) (did) (did not) view the body after death. | | | | | | |
| 22b. SIGNATURE
Robert J. Varipapa
22d. PHYSICIAN'S NAME (TYPE OR PRINT)
ROBERT J. VARIPOPA | | | | 22c. DATE SIGNED
2-8-82 | | 22e. ADDRESS
UNION MEMORIAL HOSP. |
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)
Burial | | 23b. DATE
2/10/82 | | 23c. NAME OF CEMETERY OR CREMATORY
St. Mary's Cemetery | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
Baltimore - Md |
| 24. FUNERAL DIRECTOR
NAME
Burgee Funeral Home | | | | 25a. DATE REC'D. BY REGISTRAR
FEB 9 1982 | | 25b. REGISTRAR'S SIGNATURE
<i>James J. [Signature]</i> |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medicolegal officer must be notified.

FOR
STATE
REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 2 0 3 / 0 2

REG. NO.

| | | | | | |
|--|--|---|---|---|---|
| 1. DECEASED NAME
(TYPE OR PRINT)
James Edwards | | | 2a. DATE OF DEATH
MONTH DAY YEAR
2 23 1982 | | 2b. HOUR
M |
| 3. SEX
male | 4. RACE
black | 5. DATE OF BIRTH
MONTH DAY YEAR
9 18 1926 | | 6. AGE (IN YEARS LAST BIRTHDAY)
55 YRS | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
Ala | 7b. CITIZEN OF WHAT COUNTRY?
USA | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
Baltimore city MD | |
| 10. CITY OR TOWN OF DEATH
Baltimore | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
4806 Wilvan Avenue | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE) | |
| 13a. STATE
Md | | 13b. COUNTY | 13c. CITY OR TOWN
Baltimore | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | 13e. STREET ADDRESS
4806 Wilvan Avenue |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
James Edwards Sr | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
Theresa Gee | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)
No | | 16b. SOCIAL SECURITY NO.
216-40-0615 | | 17. INFORMANT
ADDRESS
Otelia D. Edwards 4806 Wilvan Avenue | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART 1. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) massive myocardial infarction
DUE TO, OR AS A CONSEQUENCE OF:
(b) severe coronary artery disease
DUE TO, OR AS A CONSEQUENCE OF:
(c) 4100 | | | | | APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATH |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a. | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | 20b. IF YES, WERE FINDINGS USED
IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK AT WORK | | 21e. PLACE OF INJURY
(AT HOME STREET FACTORY OFFICE FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | |
| 22a. I certify that (I) (the physician attended the deceased from December 15, 1981 to February 23, 1982 , that (I) was not saw the deceased alive on February 18, 1982 and that in my own opinion death occurred on the date and hour and from the causes stated above (I) am (did not) sign the body of the death. | | | | | |
| 22b. SIGNATURE
Samuel P. Scalia, M.D. | | | | 22c. DATE SIGNED
2-28-82 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
SAMUEL P. SCALIA, M.D. | | | | 22e. ADDRESS
7 CHURCH LANE BALTIMORE, MD. 21202 | |
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)
Burial | | 23b. DATE
2/27/82 | 23c. NAME OF CEMETERY OR CREMATORY
Dulaney Valley | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
Cockeysville Md |
| 24. FUNERAL DIRECTOR
NAME ADDRESS
William C. March F/H 1101 E. North Ave | | | | 25a. DATE REC'D. BY REGISTRAR
FEB 25 1982 | |
| | | | | 25b. REGISTRAR'S SIGNATURE
Theresa Jan Math | |

2015-2016

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL HOME. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR THE DIVISION OF VITAL RECORDS. AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

MEDICAL CERTIFICATION

| STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH | | | | | | | | | | REG. NO. 8 2 0 3 7 0 3 | | | | | |
|--|--|----------------------|--|--|--|--|--|--|--|---|--|--|--|-----------------------------------|--|
| 1. DECEASED NAME
(TYPE OR PRINT) Tyrone W. Elder | | | | | | | | | | 2a. DATE KNOWN OF DEATH <input checked="" type="checkbox"/> ESTIMATED <input type="checkbox"/> 2-12-82 | | 2b. HOUR M | | | |
| 3. SEX male | | 4. RACE black | | 5. DATE OF BIRTH 9 19 43 | | 6. AGE (IN YEARS) 38 | | IF UNDER 1 YR. MONTHS DAYS | | IF UNDER 24 HRS. HOURS MIN. | | 2c. DATE PRONOUNCED DEAD 2-12-82 | | 2d. HOUR 7:45P | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MD | | | | 7b. CITIZEN OF WHAT COUNTRY? USA | | | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/> | | | | 9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City | | | |
| 10. CITY OR TOWN OF DEATH Baltimore | | | | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Union Memorial Hospital | | | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | | | | 12b. KIND OF BUSINESS OR INDUSTRY | |
| 13a. STATE MD | | | | 13b. COUNTY | | 13c. CITY OR TOWN Baltimore | | 13d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO | | 13e. STREET ADDRESS 2307 N. Aisquith St. | | | | | |
| 14. FATHER'S NAME Wesley Elder | | | | 15. MOTHER'S MAIDEN NAME Flora Bowser | | | | | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) No | | | | 16b. SOCIAL SECURITY NO. 218-40-0172 | | | | 17. INFORMANT Wesley & Flora Elder | | | | ADDRESS 2307 N. Aisquith St. | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I DEATH WAS CAUSED BY:
8147 IMMEDIATE CAUSE (a) Multiple injuries
DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.
(b) _____
DUE TO, OR AS A CONSEQUENCE OF
(c) _____ | | | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) | | | | | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | | | | | | | | 20. AUTOPSY? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO | | | |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH | | | | 21b. TIME OF INJURY 7:15PM 2-12-82 | | | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2) pedestrian struck by bus (MTA) | | | | | | | |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/> | | | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) street | | | | 21f. LOCATION 4400blk. Loch Raven Blvd. Balto., Maryland
South of Northgate | | | | | | | |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> . | | | | | | | | | | | | | | | |
| ACTUAL SIGNATURE Margarita A. Korell | | | | TITLE (SPECIFY) M.D. Assistant | | | | DATE SIGNED 2-13-82 | | | | | | | |
| EXAMINER'S NAME (TYPE OR PRINT) Margarita A. Korell, M.D. | | | | ADDRESS 111 Penn Street | | | | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | | | | 23b. DATE 2/18/82 | | 23c. NAME OF CEMETERY OR CREMATORY Baltimore Cemetery | | | | 23d. LOCATION Baltimore | | | | | |
| 24. FUNERAL DIRECTOR NAME Wm. C. March F/H | | | | ADDRESS 1101 E. North Ave. | | | | 25a. DATE REC'D. BY REGISTRAR FEB 16 1982 | | | | 25b. REGISTRAR'S SIGNATURE [Signature] | | | |

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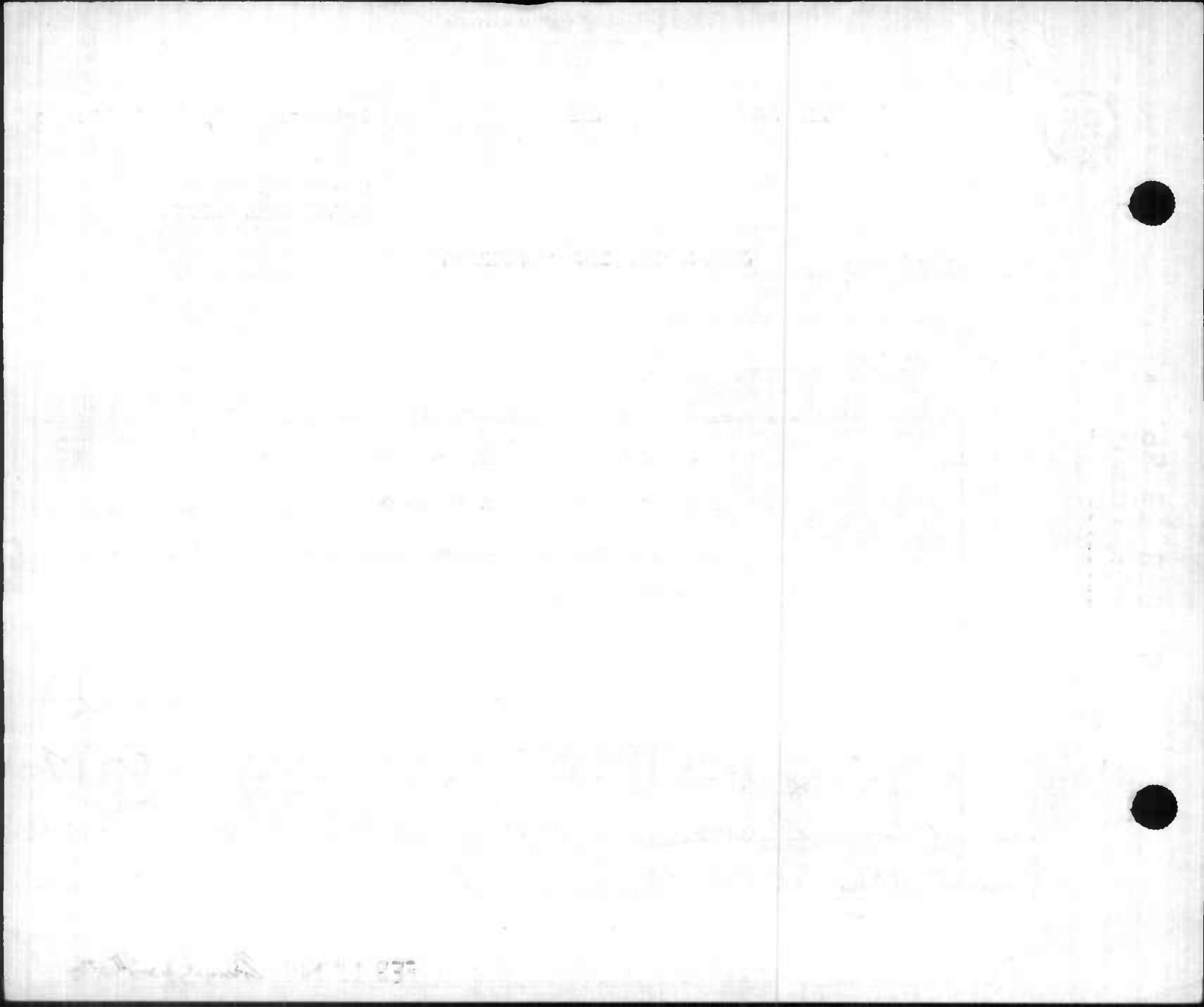
STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 2 0 3 / 0 4

FOR
STATE
REGISTRAR

REG. NO.

| | | | | | | | | | | | |
|--|--|--|---|---|--|---|--|---|-----|--|--|
| 1. DECEASED NAME
(TYPE OR PRINT)
LINDSEY (LINDSAY) ELEY | | | 2a. DATE OF DEATH
MONTH DAY YEAR
February 14, 1982 | | | 2b. HOUR
12:05a | | | | | |
| 3. SEX
Male | | 4. RACE
Black | | 5. DATE OF BIRTH
MONTH DAY YEAR
6 4 06 | | 6. AGE (IN YEARS (LAST BIRTHDAY))
75 | | 7. IF UNDER 1 YEAR
MONTHS DAYS
YRS. | | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
VA | | 7b. CITIZEN OF WHAT COUNTRY?
USA | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
BALTIMORE CITY | | | MD. | | |
| 10. CITY OR TOWN OF DEATH
Baltimore | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
JOHNS HOPKINS HOSPITAL | | | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE) | | 12b. KIND OF BUSINESS OR INDUSTRY | | | |
| 13a. STATE
MD | | 13b. CITY OR TOWN
Baltimore | | 13c. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13d. STREET ADDRESS
1608 E. Preston St. | | | | | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
Richard Eley | | | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
- | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
No | | 16b. SOCIAL SECURITY NO.
217-01-0466 | | 17. INFORMANT
ADDRESS
Thelma T. Eley 1608 E. Preston St. | | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART 1. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) RESPIRATORY DISTRESS
4292
DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b) PULMONARY EDEMA
DUE TO, OR AS A CONSEQUENCE OF
(c) ATHEROSCLEROTIC CARDIOVASCULAR DISEASE | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)
ACUTE LYMPHOCYTIC LYMPHOMA | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | | | | | |
| 21d. INJURY OCCURRED
WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | | | | | |
| 22a. I certify that (this hospital) attended the deceased from 2/14 , 19 82 to 2/14 , 19 82 , that (I) (we) lost the deceased alive on 2/13 , 19 82 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above; (I) (we) (did) view the body after death. | | | | | | | | | | | |
| 22b. SIGNATURE
John Sitakurs | | | | DEGREE
MD | | | | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> | | 22c. DATE SIGNED
2/14/82 | |
| 22d. THE PHYSICIAN'S NAME (TYPE OR PRINT)
JOHN SITAKURS | | | | 22e. ADDRESS
JOHNS HOPKINS HOSP. | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)
Burial | | 23b. DATE
2/19/82 | | 23c. NAME OF CEMETERY OR CREMATORY
Md. Nat'l Mem. Pk. | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
Laurel MD | | | | | |
| 24. FUNERAL DIRECTOR
NAME ADDRESS
Wm. C. March F/H 1101 E. North Ave. | | | | 25a. DATE REC'D. BY REGISTRAR
FEB 16 1982 | | 25b. REGISTRAR'S SIGNATURE
Thelma T. Eley | | | | | |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed in 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked on item 18 above any injury, or other traumatic event, the medical examiner must be notified.

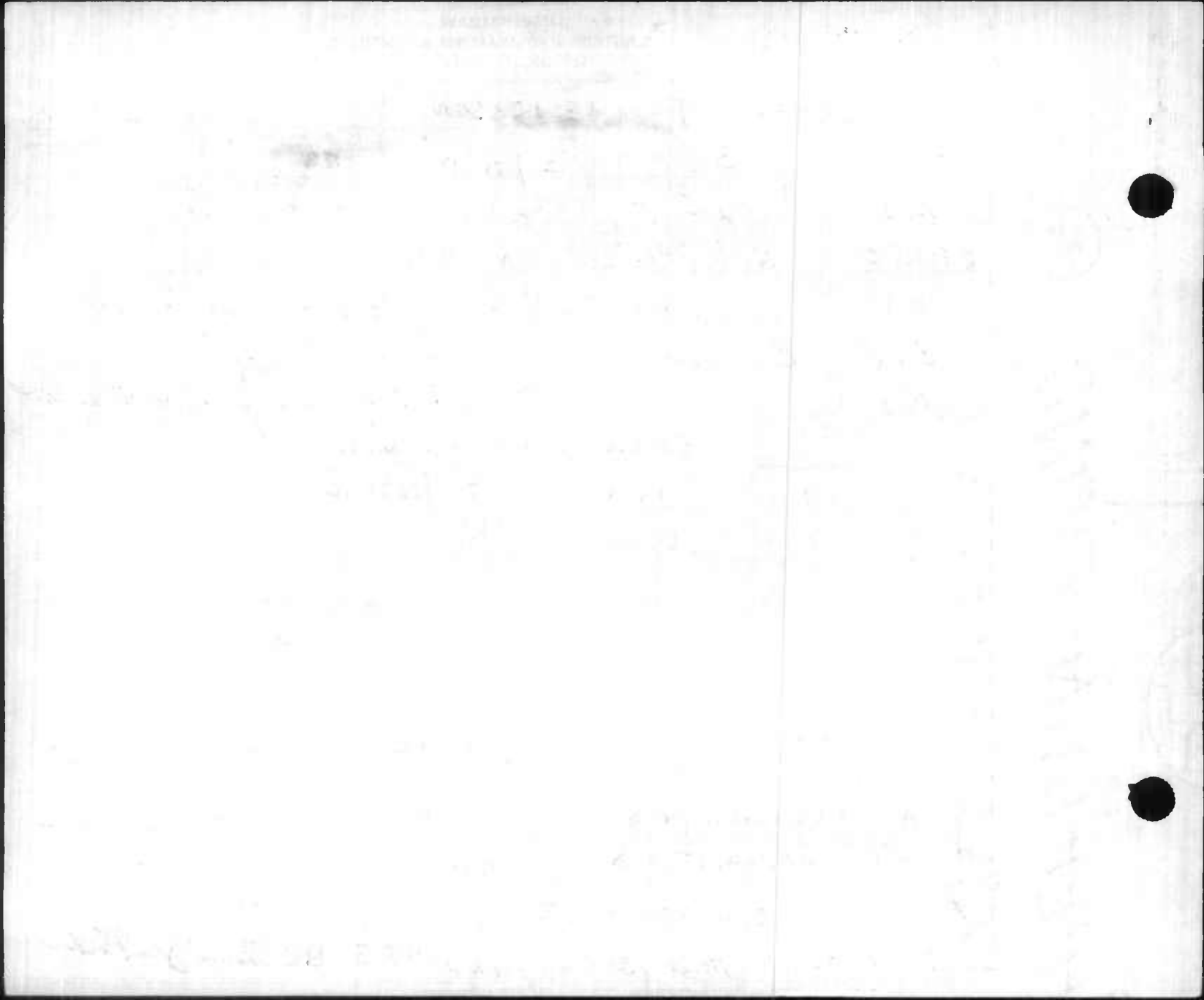
STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 2 0 3 / 0 5

1. FOR
STATE
REGISTRAR

REG. NO.

| | | | | | | | | | |
|--|--|---|--|---|--|--|---|--|--|
| 1. DECEASED NAME
(TYPE OR PRINT)
FIRST MIDDLE LAST
ZORAH T FELTEKSON | | | 2a. DATE OF DEATH
MONTH DAY YEAR
2/28/82 | | | 2b. HOUR
9:15 P.M. | | | |
| 3. SEX
F | | 4. RACE
B | | 5. DATE OF BIRTH
MONTH DAY YEAR
2/21/18 | | 6. AGE
YEARS MONTHS DAYS
64 | | 7. IF UNDER 1 YEAR
MONTHS DAYS HOURS MIN.
YRS. | |
| 7a. BIRTHPLACE
(STATE OR FOREIGN COUNTRY)
MD | | 7b. CITIZEN OF WHAT COUNTRY?
U.S.A | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
Balto. City MD. | | | |
| 10. CITY OR TOWN OF DEATH
BALTO | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
NORTH CHARLES GEN. HOSP | | | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
FUNERAL DIRECTOR | | 12b. KIND OF BUSINESS OR INDUSTRY | |
| 13a. STATE
md | | 13b. COUNTY | | 13c. CITY OR TOWN
BALTO | | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS
5603 Lauretta Ave | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
Earl Bundy | | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
Alice Elliott | | | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
No | | | |
| 16b. IF YES, GIVE WAR OR DATES | | | 16c. SOCIAL SECURITY NO. | | | 17. INFORMANT
ADDRESS
Zora Betty Logan 5603 Lauretta Ave | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART 1. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Severe renal failure
2500
DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b) Urinary tract infection
DUE TO, OR AS A CONSEQUENCE OF
(c) Diabetes mellitus | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) | | | | | | | | | |
| 19a. DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK AT WORK | | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 1/26/82 to 2/28/82 , that (I) (we) lost
saw the deceased alive on 2/28/82 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated
above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | |
| 22b. SIGNATURE
A.C. Chauvalit, M.D. | | | DEGREE | | | ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> | | 22c. DATE SIGNED
2/28/82 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
A.C. CHOUVALIT, M.D. | | | 22e. ADDRESS
NORTH CHARLES GEN. HOSP. | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)
Burial | | | 23b. DATE
3/14/82 | | 23c. NAME OF CEMETERY OR CREMATORY
Balto. National | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
5501 Frederick Ave | | |
| 24. FUNERAL DIRECTOR
NAME
LOCKS FUNERAL HOME | | | ADDRESS
13047 Central Ave | | | 25a. DATE REC'D. BY REGISTRAR
MAR 3 1982 | | | |
| 25b. REGISTRAR'S SIGNATURE
James J. Kathan | | | | | | | | | |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

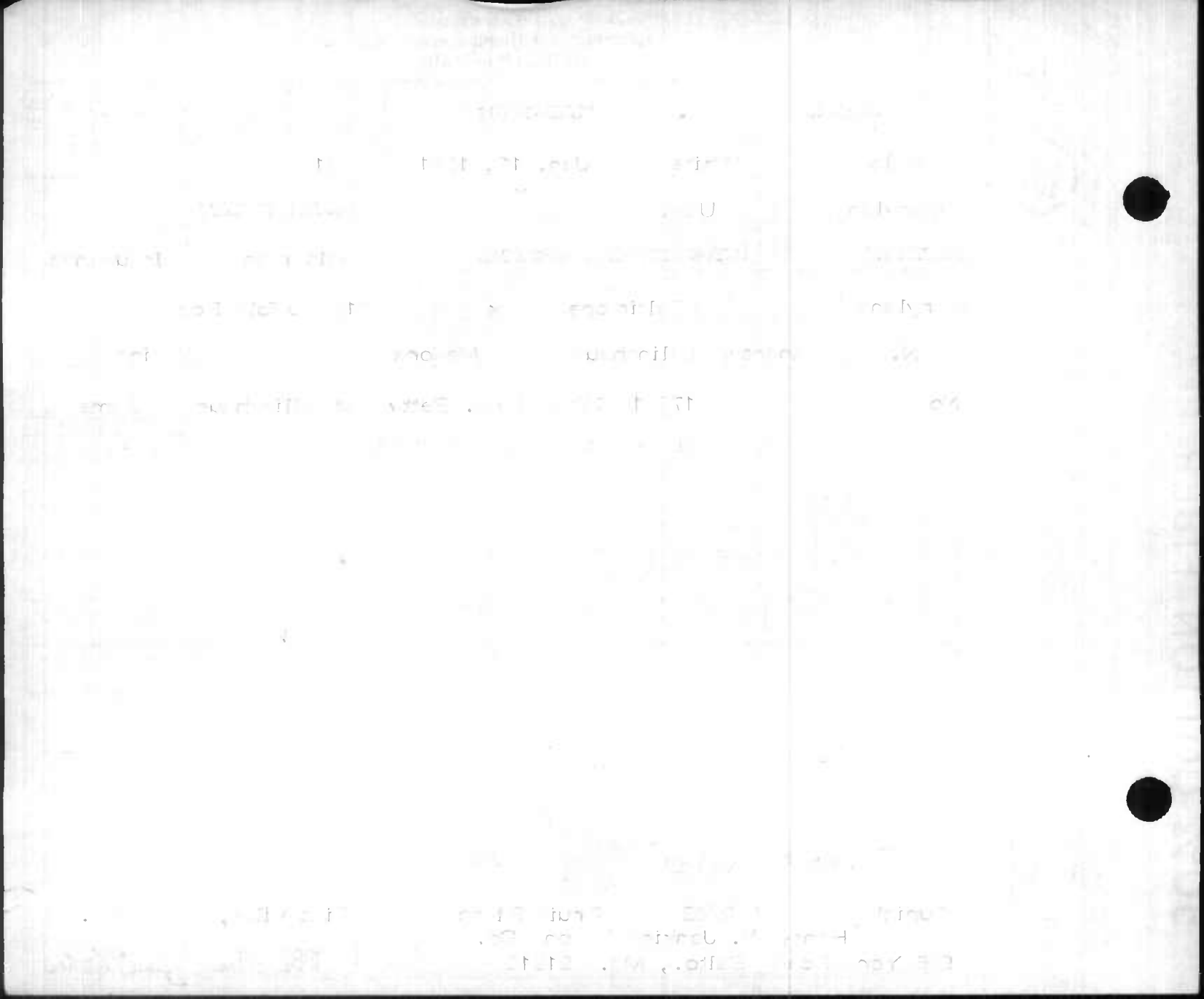
1 - FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 2 0 3 / 0 6

REG. NO.

| | | | | | |
|---|--|--|--|---|--|
| 1. DECEASED NAME
(TYPE OR PRINT)
RICHARD A. ELLINGHAUS | | | 2a. DATE OF DEATH
MONTH DAY YEAR
02 28 82
2b. HOUR
4 10 a.m. | | |
| 3. SEX
Male | 4. RACE
White | 5. DATE OF BIRTH
MONTH DAY YEAR
Jan. 13, 1921 | | 6. AGE (IN YEARS LAST BIRTHDAY)
61 YRS. | 7. IF UNDER 1 YEAR
MONTHS DAYS HOURS MIN. |
| 8. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
Maryland | 9. CITIZEN OF WHAT COUNTRY?
USA | 10. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 11. BALTIMORE CITY OR COUNTY OF DEATH
BALTIMORE CITY MD. | |
| 12. CITY OR TOWN OF DEATH
BALTIMORE | 13. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
UNION MEMORIAL HOSPITAL | | | 14. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
Salesman | |
| 15. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)
15a. STATE Maryland 15b. COUNTY Baltimore 15c. CITY OR TOWN Baltimore 15d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | 16. STREET ADDRESS
312 Suffolk Road | | |
| 17. FATHER'S NAME
FIRST MIDDLE LAST
N. Andrew Ellinghaus | | 18. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
Medora Wakins | | | |
| 19. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
No | | 20. SOCIAL SECURITY NO.
(IF YES, GIVE WAR OR DATES)
178 16 7936 | | 21. INFORMANT
ADDRESS
Mrs. Betty Lee Ellinghaus Same | |
| 22. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART 1. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) IMMUNOBLASTIC LYMPHOMA
2008
DUE TO, OR AS A CONSEQUENCE OF
(b) _____
DUE TO, OR AS A CONSEQUENCE OF
(c) _____
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: 10. | | | | | |
| 23. DATE OF OPERATION | | 24. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 25. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 26. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER NOTIFY MEDICAL EXAMINER) | | 27. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 28. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | |
| 29. INJURY OCCURRED
WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 30. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 31. LOCATION
CITY OR TOWN COUNTY STATE | |
| 32. I certify that (1) (this hospital) attended the deceased from 2/29/82, 19, to 2/28/82, 19, that (1) (we) last saw the deceased alive on 2/28, 19, 82, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (1) (we) (did) (did not) view the body after death. | | | | | |
| 33. SIGNATURE
JERARD WARD | | | | 34. DATE SIGNED
2/28/82 | |
| 35. PHYSICIAN'S NAME (TYPE OR PRINT)
JERARD WARD | | | | 36. ADDRESS
UNION MEMORIAL HOSP. | |
| 37. BURIAL, CREMATION, REMOVAL
(SPECIFY)
Burial | | 38. DATE
3/2/82 | | 39. NAME OF CEMETERY OR CREMATORY
Druid Ridge | |
| 40. FUNERAL DIRECTOR
NAME
Henry W. Jenkins & Sons Co.
ADDRESS
4905 York Road Balto., Md. 21212 | | 41. DATE REC'D. BY REGISTRAR
MAR 1 1982 | | 42. REGISTRAR'S SIGNATURE
Theresa Jean Nantzen | |

BP



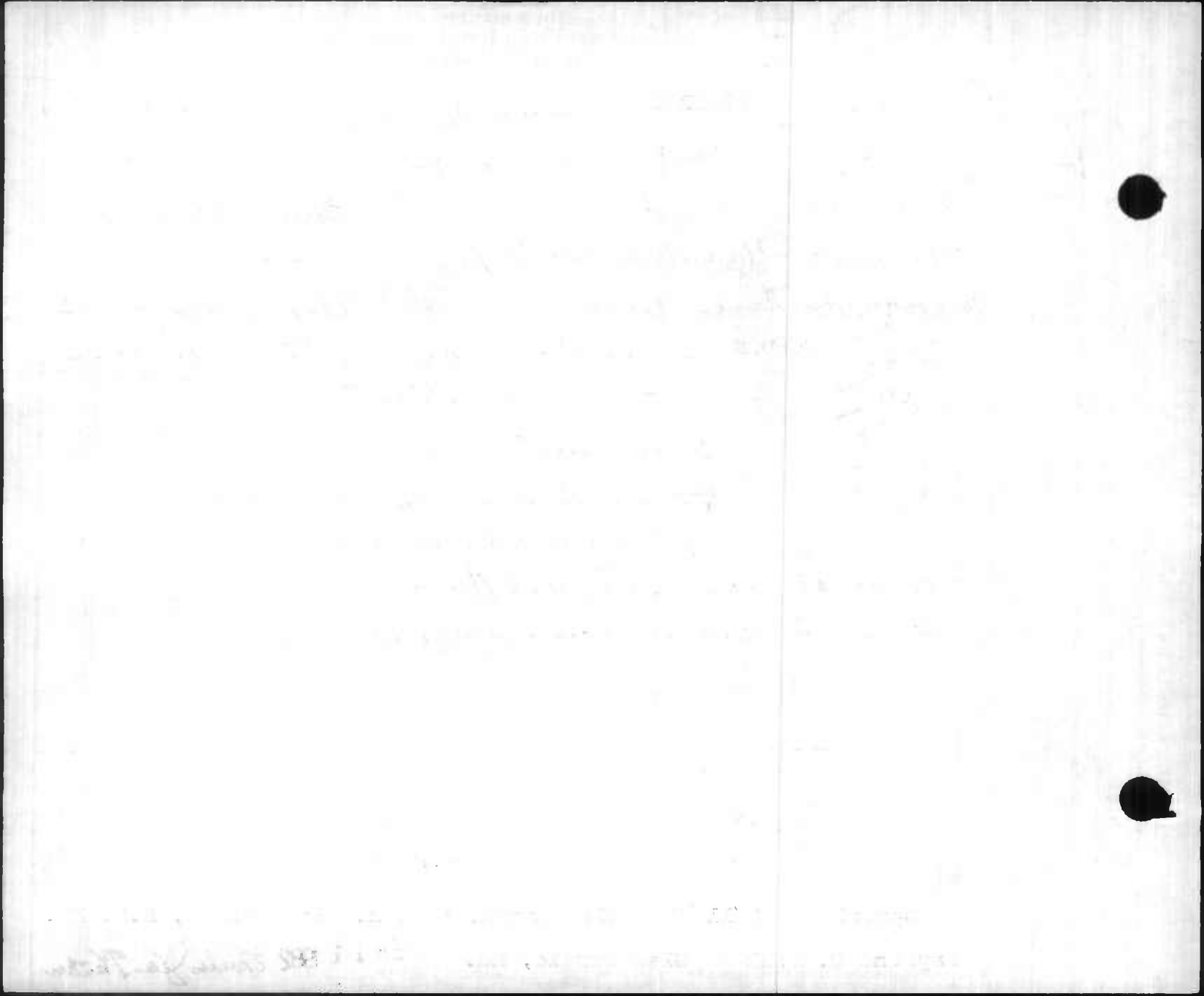
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 2 0 3 1 0 1

REG. NO.

1 - FOR
STATE
REGISTRAR

| | | | | | | | | | |
|---|--|--|--|---|--|---|--|--|--|
| 1. DECEASED NAME
(TYPE OR PRINT) ERIC MICHAEL ENDERS | | | 2a. DATE OF DEATH
MONTH DAY YEAR
02 09 82 | | | 2b. HOUR
1:45 AM | | | |
| 3. SEX
Male | | 4. RACE
Cauc | | 5. DATE OF BIRTH
MONTH DAY YEAR
01 16 82 | | 6. AGE (IN YEARS LAST BIRTHDAY)
YRS. MONTHS DAYS
24 | | 6. IF UNDER 1 YEAR
IF UNDER 24 HRS.
HOURS MIN. | |
| 7. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
MARYLAND | | 7b. CITIZEN OF WHAT COUNTRY?
U.S.A. | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
BALTIMORE CITY MD. | | | |
| 10. TOWN OF DEATH
BALTIMORE | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
UNIV. MARYLAND Hosp. | | | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE) | | 12b. KIND OF BUSINESS OR INDUSTRY | |
| 13a. STATE
MARYLAND | | 13b. COUNTY
ANNE ARUNDEL | | 13c. CITY OR TOWN
SEVERN | | 13d. INSIDE CITY LIMITS?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 13e. STREET ADDRESS
1709 CARRIAGE CIRCLE | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
SCOTT GORDON ENDERS Sr. | | | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
JUDY KAY MOSCHEL | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
NO | | 16b. SOCIAL SECURITY NO.
— | | 17. INFORMANT
Hospital CHART | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART 1. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) CARDIAC ARREST
7463
DUE TO, OR AS A CONSEQUENCE OF:
(b) CONGENITAL AORTIC STENOSIS, COARCTATION
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(c) of AORTA, VENTRICULAR SEPTAL DEFECT | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a
01 23 82 REPAIR COARCTATION AORTA | | | | | | | | | |
| 19a. DATE OF OPERATION
02 09 82 | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED
AORTIC STENOSIS/VENTRICULAR DEFECT | | | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) | | | | | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET
— | | CITY OR TOWN
— | | COUNTY
— | |
| 21g. STATE
— | | | | | | | | | |
| 22a. I certify that (1) the hospital attended the deceased from 02 09 82 to 02 09 82 , that (1) the last saw the deceased alive on 02 09 82 , and that in (my) own opinion death occurred on the date and hour and from the causes stated above, (1) we did (did not) view the body after death. | | | | | | | | | |
| 22b. SIGNATURE
Anthony L. Moulton | | | | DEGREE
MD. | | | | 22c. DATE SIGNED
2/9/82 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
ANTHONY L. MOULTON | | | | 22e. ADDRESS
Div. Cardiac Surgery / Univ. Maryland Hosp. | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)
Burial | | 23b. DATE
2/11/82 | | 23c. NAME OF CEMETERY OR CREMATORY
Glen Haven. Mem. Pk. | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
Glen Burnie, A.A. Md. | | | |
| 24. FUNERAL DIRECTOR
NAME
Raymond C. Fink | | | | ADDRESS
Glen Burnie, Md. | | 25a. DATE REC'D. BY REGISTRAR
FEB 11 1982 | | 25b. REGISTRAR'S SIGNATURE
James J. Nathan | |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. It may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the registrator, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

| STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH | | | | | | | | | | REG. NO. | |
|--|--|--|--|---|--|---|--|---|--|--|--|
| 1. DECEASED NAME
(TYPE OR PRINT) FIRST <u>SELMA</u> MIDDLE <u>Epstein</u> LAST <u>EPSTEIN</u> | | | | | | 2a. DATE OF DEATH
MONTH <u>2</u> DAY <u>10</u> YEAR <u>82</u> | | 2b. HOUR
<u>6:43</u> P M | | | |
| 3. SEX
<u>FEMALE</u> | | 4. RACE
<u>CAUCASIAN</u> | | 5. DATE OF BIRTH
MONTH <u>10</u> DAY <u>10</u> YEAR <u>1900</u> | | 6. AGE (IN YEARS LAST BIRTHDAY)
<u>81</u> YRS | | IF UNDER 1 YEAR
MONTHS <u></u> DAYS <u></u> HOURS <u></u> MIN. <u></u> | | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
<u>NEW YORK</u> | | 7b. CITIZEN OF WHAT COUNTRY?
<u>USA</u> | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOW <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
<u>BALTO CITY</u> MD. | | | | | |
| 10. CITY OR TOWN OF DEATH
<u>BALTO</u> | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
<u>Sinai Hospital</u> | | | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
<u>HOUSEWIFE</u> | | 12b. KIND OF BUSINESS OR INDUSTRY
<u>AT HOME</u> | | | |
| 13a. STATE
<u>MARYLAND</u> | | 13b. COUNTY
<u>BALTO.</u> | | 13c. CITY OR TOWN
<u>BALTIMORE</u> | | 13d. INSIDE CITY LIMITS?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 13e. STREET ADDRESS
<u>8522 GREEN LA. #21207</u> | | | |
| 14. FATHER'S NAME
FIRST <u>Nathan</u> MIDDLE <u></u> LAST <u>KAPLAN</u> | | | | 15. MOTHER'S MAIDEN NAME
FIRST <u>GLADYS</u> MIDDLE <u>ZEMBELIST</u> UNKNOWN | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES OR UNKNOWN)
<u>NO</u> | | 16b. SOCIAL SECURITY NO.
<u>058-01-9671</u> | | 17. INFORMANT
<u>MRS. BEVERLY MALCHODI</u> | | 17a. ADDRESS
<u>8522 GREEN LA. BALTO., MD</u> | | 17b. CITY OR TOWN
<u>21207</u> | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART 1. DEATH WAS CAUSED BY:
<u>4100</u> IMMEDIATE CAUSE (a) <u>Acute Myocardial Infarction:</u>
DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost
(b) <u>Cardiogenic Shock:</u>
DUE TO, OR AS A CONSEQUENCE OF
(c) <u></u> | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a) <u></u> | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER NOTIFY MEDICAL EXAMINER) | | | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
<u></u> P.M. <u>19</u> | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | | | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK | | | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from <u></u> , 19 <u></u> , to <u></u> , 19 <u></u> , that (I) (we) lost <u></u> saw the deceased alive on <u></u> , 19 <u></u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | | | |
| 22b. SIGNATURE
<u>D. S. PATEL</u> | | | | | | DEGREE
<u>MD</u> | | ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | 22c. DATE SIGNED
<u>2/10/82</u> | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
<u>D. S. PATEL</u> | | | | | | 22e. ADDRESS
<u>SINAI HOSPITAL</u> | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY) <u>BURIAL</u> | | | | 23b. DATE
<u>FEB. 12, 1982</u> | | 23c. NAME OF CEMETERY OR CREMATORY
<u>BALTIMORE HEBREW</u> | | 23d. LOCATION
CITY OR TOWN <u>REISTERSTOWN</u> COUNTY <u>BALTO.</u> STATE <u>MD</u> | | | |
| 24. FUNERAL DIRECTOR
NAME <u>SOL LEVINSON & BROS., INC.</u> ADDRESS <u>6010 REISTERSTOWN RD. BALTO., MD 21215</u> | | | | | | 25a. DATE REC'D. BY REGISTRAR
<u>FEB 17 1982</u> | | 25b. REGISTRAR'S SIGNATURE
<u>James J. North</u> | | | |



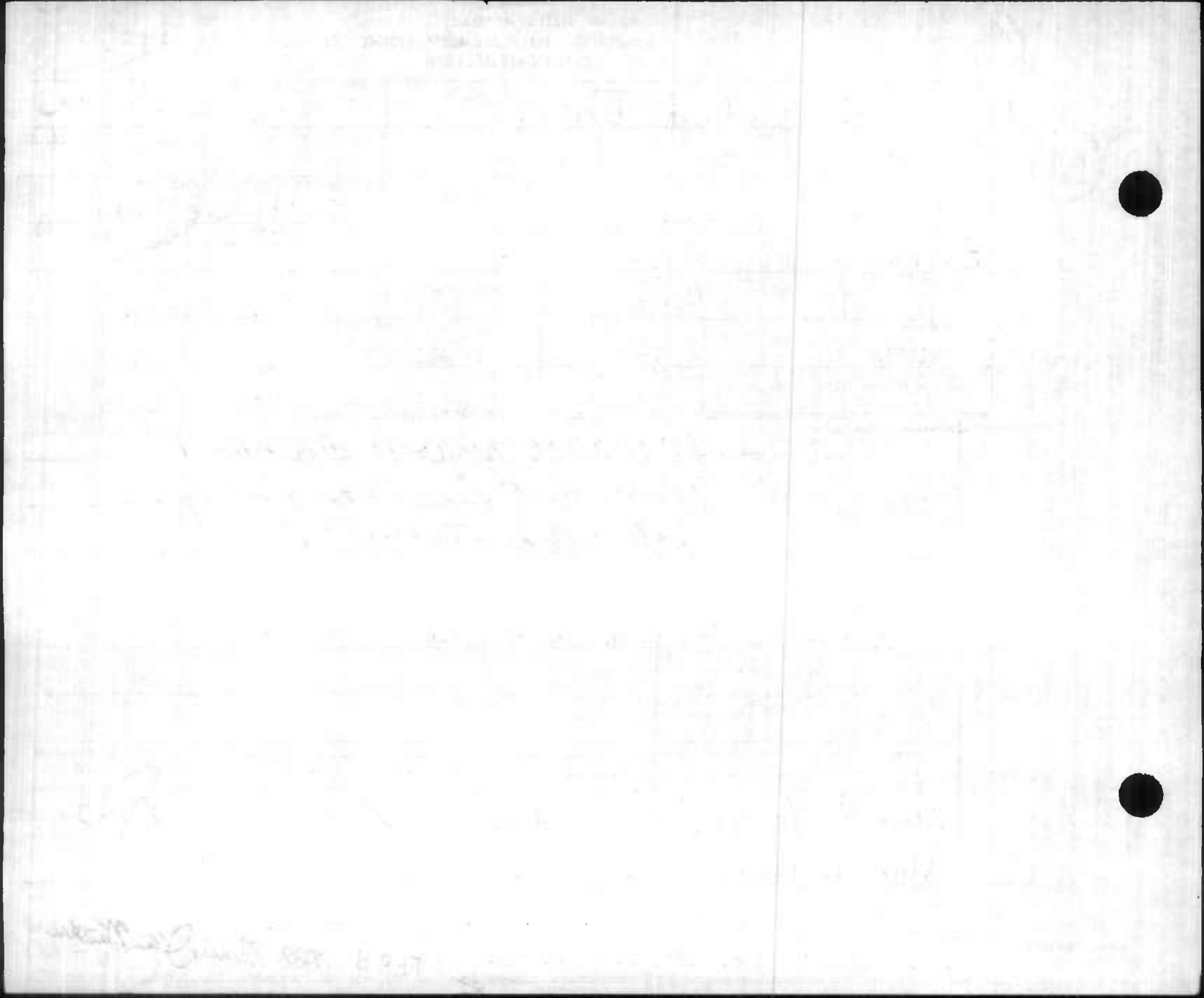
FEB 15 1945

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH | | | | 8 2 0 3 7 0 9 | | | |
|---|--|--|--|--|--|--|--|
| FOR
1. STATE REGISTRAR | | | | REG. NO. | | | |
| DECEASED NAME
(TYPE OR PRINT) | | | | 2a. DATE OF DEATH | | | |
| FIRST MIDDLE LAST
Crawford Ervin | | | | MONTH DAY YEAR
2 4 82 | | | |
| 3. SEX | | | | 2b. HOUR | | | |
| Male | | | | 7 52 P.M. | | | |
| 4. RACE | | 5. DATE OF BIRTH | | 6. AGE (IN YEARS LAST BIRTHDAY) | | IF UNDER 1 YEAR | |
| Black | | MONTH DAY YEAR
10 23 28 | | 53 YRS. | | IF UNDER 24 HRS. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) | | 7b. CITIZEN OF WHAT COUNTRY? | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH | |
| Rockhill, SC | | U.S.A. | | | | Baltimore City MD. | |
| 10. CITY OR TOWN OF DEATH | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | | 12b. KIND OF BUSINESS OR INDUSTRY | |
| Baltimore | | PROVIDENT HOSPITAL | | | | | |
| 13a. STATE | | | | 13b. COUNTY | | | |
| MD | | | | Baltimore | | | |
| 14. FATHER'S NAME | | | | 15. MOTHER'S MAIDEN NAME | | | |
| FIRST MIDDLE LAST
William Ervin | | | | FIRST MIDDLE LAST
Ophelia Mobley | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) | | | | 16b. SOCIAL SECURITY NO. | | | |
| No | | | | N/A | | | |
| 17. INFORMANT | | | | ADDRESS | | | |
| Charles Ervin | | | | 3314 The Alameda | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | | |
| IMMEDIATE CAUSE (a) 5609 Probable myocardial infarct | | | | | | | |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last | | | | (b) Persistent hypotension and arrhythmia | | | |
| | | | | (c) Intestinal obstruction. | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? | |
| 2/3/82 | | Intestinal Obstruction | | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | |
| | | HOUR A.M. MONTH DAY YEAR
P.M. 19 | | | | | |
| 21d. INJURY OCCURRED | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION | | | |
| WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | | | STREET CITY OR TOWN COUNTY STATE | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) lost saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) not view the body after death. | | | | | | | |
| 22b. SIGNATURE | | | | DEGREE | | 22c. DATE SIGNED | |
| Miles G. Harrison Jr. | | | | M.D. | | 2/4/82 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) | | | | 22e. ADDRESS | | | |
| Miles G. Harrison Jr. | | | | 2300 Garrison Blvd. | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) | | 23b. DATE | | 23c. NAME OF CEMETERY OR CREMATORY | | 23d. LOCATION | |
| Burial | | 2/10/82 | | MD. VET. CEM. | | Crownsville | |
| 24. FUNERAL DIRECTOR | | | | 25a. DATE REC'D. BY REGISTRAR | | | |
| NAME
Wm. C. March F/H, Inc. 1101 E. North Ave. | | | | FEB 8 1982 | | | |



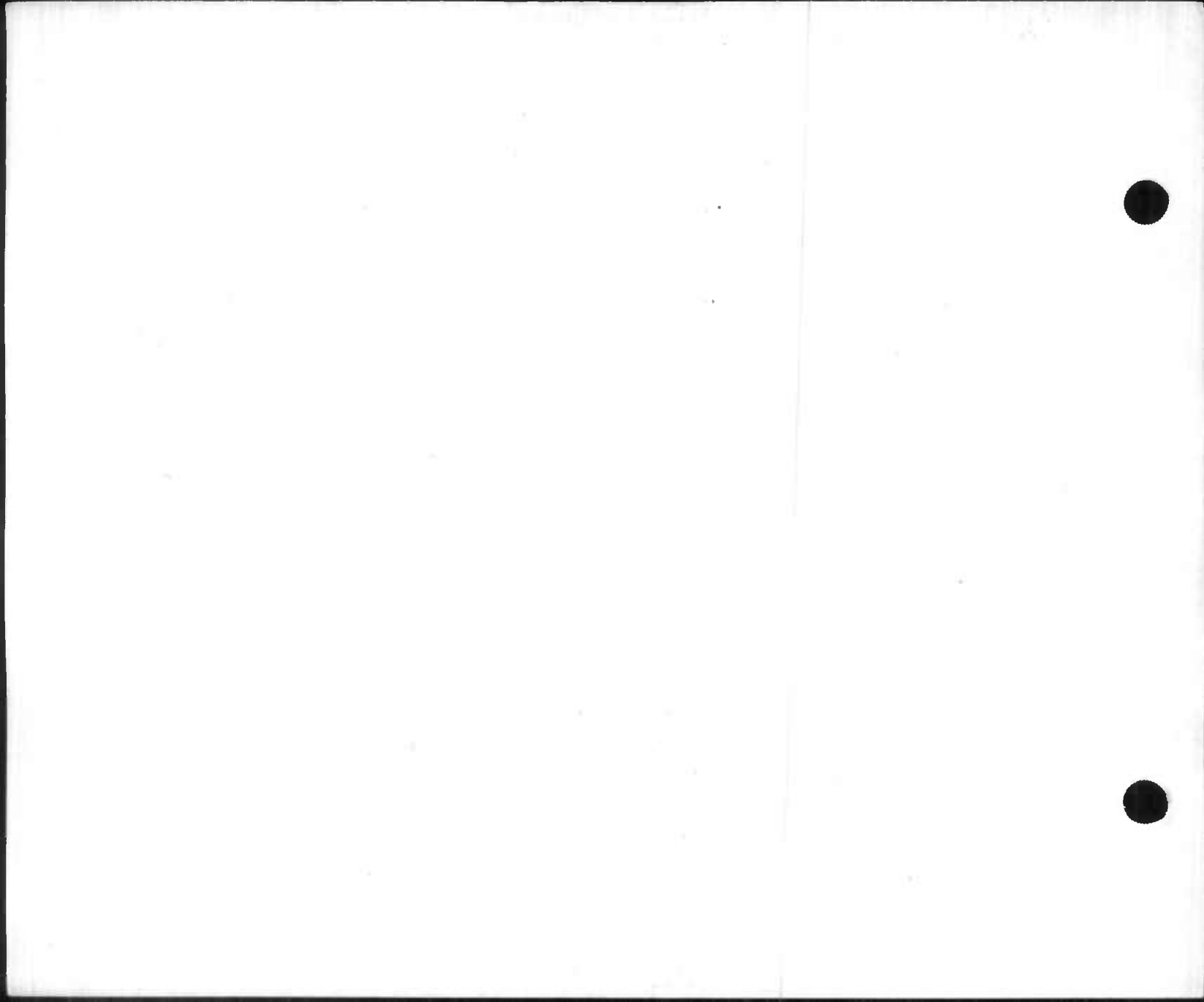
STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 2 0 3 / 1 0

1 - FOR
STATE
REGISTRAR

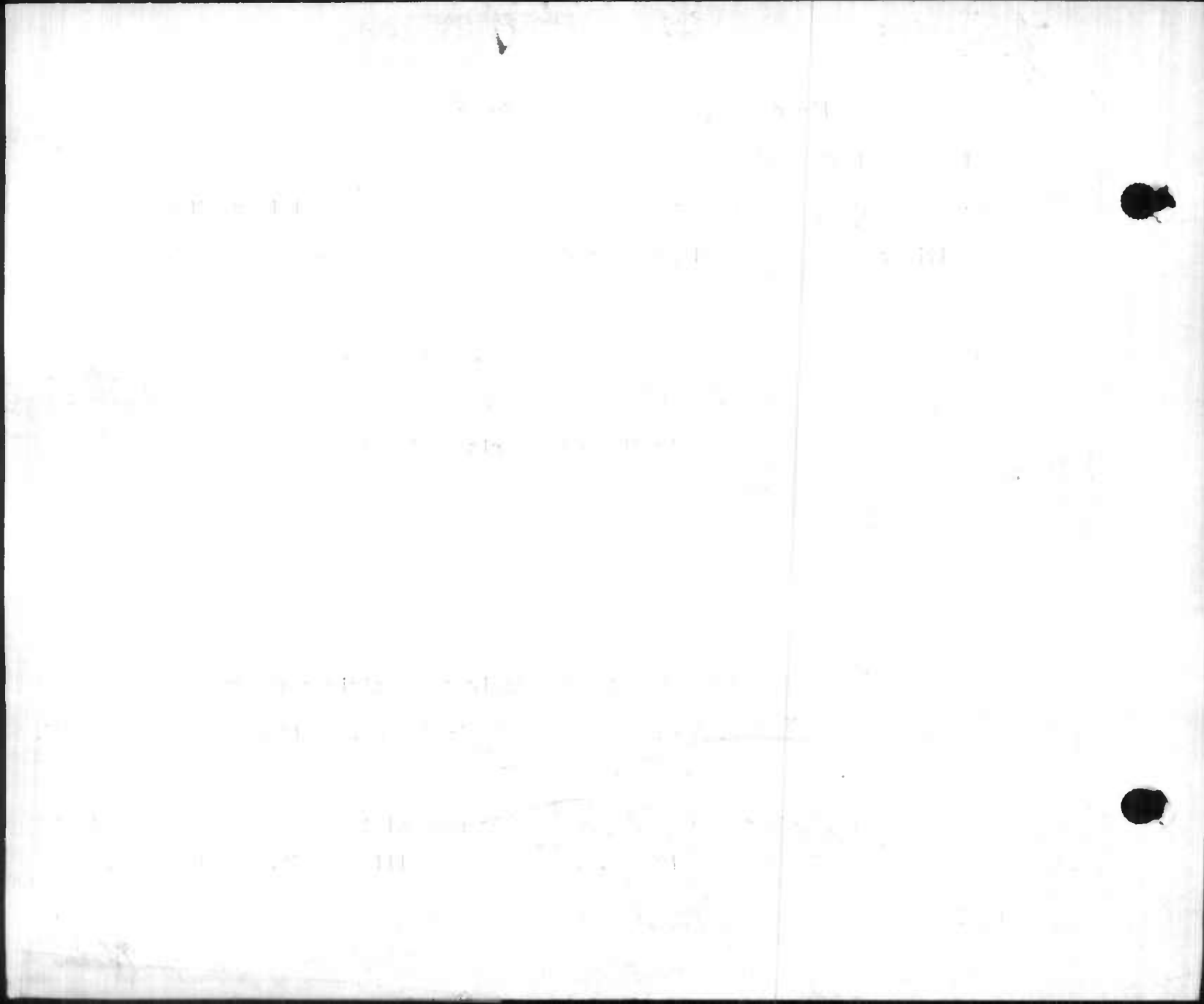
REG. NO.

| | | | | | |
|--|---|--|--|---|--|
| 1. DECEASED NAME
(TYPE OR PRINT) FIRST MIDDLE LAST
(Sonny) Elijah Evans | | | 2a. DATE OF DEATH MONTH DAY YEAR
2 1 82 | | 2b. HOUR
M |
| 3 SEX
male | 4 RACE
black | 5 DATE OF BIRTH
MONTH DAY YEAR
11 5 23 | 6 AGE (IN YEARS LAST BIRTHDAY)
58 YRS | 7. IF UNDER 1 YEAR
MONTHS DAYS
IF UNDER 24 HRS
HOURS MIN. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
VA | 7b. CITIZEN OF WHAT COUNTRY?
USA | 8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 9 BALTIMORE CITY OR COUNTY OF DEATH
Baltimore city MD. | | |
| 10 CITY OR TOWN OF DEATH
Baltimore | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
2816 Harlem Avenue | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE) | | 12b. KIND OF BUSINESS OR INDUSTRY |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)
13a. STATE
Md | | 13b. COUNTY
Baltimore | 13c. CITY OR TOWN
Baltimore | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
Alexander Evans | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
Lucy Bennis | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)
No | | 16b. SOCIAL SECURITY NO.
217-14-0731 | 17 INFORMANT ADDRESS
Lottie Evans 2816 Harlem Avenue | | |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY
IMMEDIATE CAUSE (a) <u>SQUAMOUS CELL CARCINOMA OF LUNG</u>
1629
DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost
(b) _____
DUE TO, OR AS A CONSEQUENCE OF
(c) _____
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
7 mos | | | | | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK AT WORK | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | |
| 22a. I certify that (1) (this hospital) attended the deceased from <u>AUGUST 19 82</u> , to <u>FEBRUARY 19 82</u> , that (1) (we) lost
saw the deceased alive on <u>1/26 19 82</u> , and that in (m) (our) opinion death occurred on the date and hour and from the causes stated
above, (1) (we) (did) (did not) view the body after death. | | | | | |
| 22b. SIGNATURE
<u>Donald R. Lurye, MD</u> | | DEGREE
MD | | 22c. DATE SIGNED
2/2/82 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
<u>DONALD R. LURYE, MD</u> | | 22e. ADDRESS
<u>22 SO. GREENE ST., BALTIMORE, MD 21201</u> | | | |
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)
Burial | 23b. DATE
2/6/82 | 23c. NAME OF CEMETERY OR CREMATORY
King Memorial Pk. | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
Baltimore Co MD | |
| 24. FUNERAL DIRECTOR
NAME ADDRESS
William C. March F/H 1101 E. North Ave | | 25a. DATE REC'D. BY REGISTRAR
FEB 3 1982 | | | |
| | | 25b. REGISTRAR'S SIGNATURE
<u>James J. [Signature]</u> | | | |



TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITH PAGES 3 AND 4 AFTER DEATH. WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

| STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH | | | | | | | | | | REG. NO. 2 0 3 7 1 1 | | |
|---|---------------|--|--|---|--|--|---|---|--|---|------------|------------------|
| 1. DECEASED NAME
(TYPE OR PRINT) Oliver Wendell Evans | | | | | | | | | | 2a. DATE KNOWN OF DEATH
MONTH DAY YEAR 2 23 1982 | | 2b. HOUR M 3:32A |
| 3. SEX Male | 4. RACE Black | 5. DATE OF BIRTH
MONTH DAY YEAR Nov 12 48 | | 6. AGE (IN YEARS)
(LAST BIRTHDAY) 33 YRS. | IF UNDER 1 YR.
MONTHS DAYS HOURS MIN | | IF UNDER 24 HRS.
HOURS MIN | | 2c. DATE PRONOUNCED DEAD
MONTH DAY YEAR 2 23 1982 | | 2d. HOUR M | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Balto. Md | | 7b. CITIZEN OF WHAT COUNTRY? USA | | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City, MD | | | | | |
| 10. CITY OR TOWN OF DEATH Baltimore | | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 4 Woodington Road | | | | 12a. USUAL OCCUPATION (TYPE OF WORK OR MOST OF WORKING LIFE) Fork Lift Operator | | 12b. KIND OF BUSINESS OR INDUSTRY | | | | |
| USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) | | | | | | | | | | | | |
| 13a. STATE Md | | 13b. COUNTY | | 13c. CITY OR TOWN Balto. | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS 2331 W. Lanvale ST | | | | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST Thelms Evans Sr | | | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST Dolores C. Lomas | | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO, OR UNKNOWN) Yes | | 16b. SOCIAL SECURITY NO. 1968-1970 215-52-3353 | | 17. INFORMANT
ADDRESS Dolores C. Evans, 2331 W. Lanvale | | | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Aspiration of gastric contents
DUE TO, OR AS A CONSEQUENCE OF
(b)
DUE TO, OR AS A CONSEQUENCE OF
(c) | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a). | | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | | | | | | 20. AUTOPSY?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | |
| 21a. EXTERNAL CAUSE WAS
UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH | | | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR ? PM 2 23 1982 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) Aspirated gastric contents | | | | | | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/>
AT WORK AT WORK | | | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) house | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE
4 Woodington Rd. Balto. Md. | | | | | | |
| 22a. I certify that I took charge of the remains described above, held on death resulted from: natural causes <input type="checkbox"/> accident <input checked="" type="checkbox"/> suicide <input type="checkbox"/> homicide <input type="checkbox"/> undetermined manner <input type="checkbox"/> .
Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion | | | | | | | | | | | | |
| ACTUAL SIGNATURE Thomas D. Smith | | | | TITLE (SPECIFY) M.D. Deputy Chief | | | | MEDICAL EXAMINER DATE SIGNED 2/23/82 | | | | |
| EXAMINER'S NAME (TYPE OR PRINT) Thomas D. Smith, M.D. | | | | ADDRESS 111 Penn St. Balto., MD. | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | | | | 23b. DATE 2/26/82 | | 23c. NAME OF CEMETERY OR CREMATORY Arbutus Mem. PK | | 23d. LOCATION (CITY OR TOWN) COUNTY STATE Arbutus Balto. Md | | | | |
| 24. FUNERAL DIRECTOR | | | | 25a. DATE REC'D. BY REGISTRAR | | | | 25b. REGISTRAR'S SIGNATURE | | | | |
| Dunnell B. Allen Balto. Md | | | | FEB 25 1982 | | | | Frances Jean Nathan | | | | |



TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

DHMH - 16 50M 1/81
(VRA 15, 4)

| STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH | | | | REG. NO. 8 2 0 3 7 1 2 | | | |
|--|--|---|--|--|--|---|--|
| 1. FOR STATE REGISTRAR | | | | 2a. DATE OF DEATH MONTH DAY YEAR | | | |
| 1 DECEASED NAME FIRST MIDDLE LAST
Pauline C. Fagan | | | | 2b. HOUR
5:10a M | | | |
| 3 SEX
Female | | 4 RACE
White | | 5. DATE OF BIRTH MONTH DAY YEAR
Nov. 4, 1917 | | 6 AGE (IN YEARS LAST BIRTHDAY) YRS. MONTHS DAYS
64 | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
Maryland | | 7b. CITIZEN OF WHAT COUNTRY?
U.S.A. | | 8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9 BALTIMORE CITY OR COUNTY OF DEATH
Baltimore City MD. | |
| 10 CITY OR TOWN OF DEATH
Baltimore | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
Maryland General Hospital | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)
Saleslady | | 12b. KIND OF BUSINESS OR INDUSTRY
Food Store | |
| 13a. STATE
Md. | | 13b. COUNTY
Balto. | | 13c. CITY OR TOWN
Reisterstown | | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 14 FATHER'S NAME FIRST MIDDLE LAST
William Lewis, Jr. | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST
Mary Emma Reynolds | | 17. INFORMANT ADDRESS
John A. Fagan 12 Virginia Avenue, Reisterstown, Md. | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)
No | | 16b. SOCIAL SECURITY NO.
216-52-5447 | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART 1: DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Metastatic Adenocarcinoma</u>
1991
DUE TO, OR AS A CONSEQUENCE OF (b) _____
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last } DUE TO, OR AS A CONSEQUENCE OF (c) _____
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH _____ | | | | | | | |
| PART 2: OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a) _____ | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | |
| 22a. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from January 26, 1982, to February 4, 1982, that <input checked="" type="checkbox"/> (we) last saw the deceased alive on February 4, 1982, and that in my (our) opinion death occurred on the date and hour and from the causes stated above, <input checked="" type="checkbox"/> (we) (did) (XXXX) view the body after death. | | | | | | | |
| 22b. SIGNATURE <u>Mohammad Aslam M.D.</u> DEGREE <u>M.D.</u> | | | | ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> | | 22c. DATE SIGNED | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
Mohammad Aslam, M.D. | | | | 22e. ADDRESS
C/O Maryland General Hospital | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)
Burial | | 23b. DATE
Feb. 6, 1982 | | 23c. NAME OF CEMETERY OR CREMATORY
Evergreen Memorial Gardens | | 23d. LOCATION CITY OR TOWN COUNTY STATE
Finksburg, Carroll, Md. | |
| 24. FUNERAL DIRECTOR NAME <u>H. E. Schmitt</u> ADDRESS <u>Owings Mills, Md.</u> | | | | 25a. DATE REC'D. BY REGISTRAR <u>FEB 6 1982</u> REGISTRAR'S SIGNATURE <u>[Signature]</u> | | | |

BP 10

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be completed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

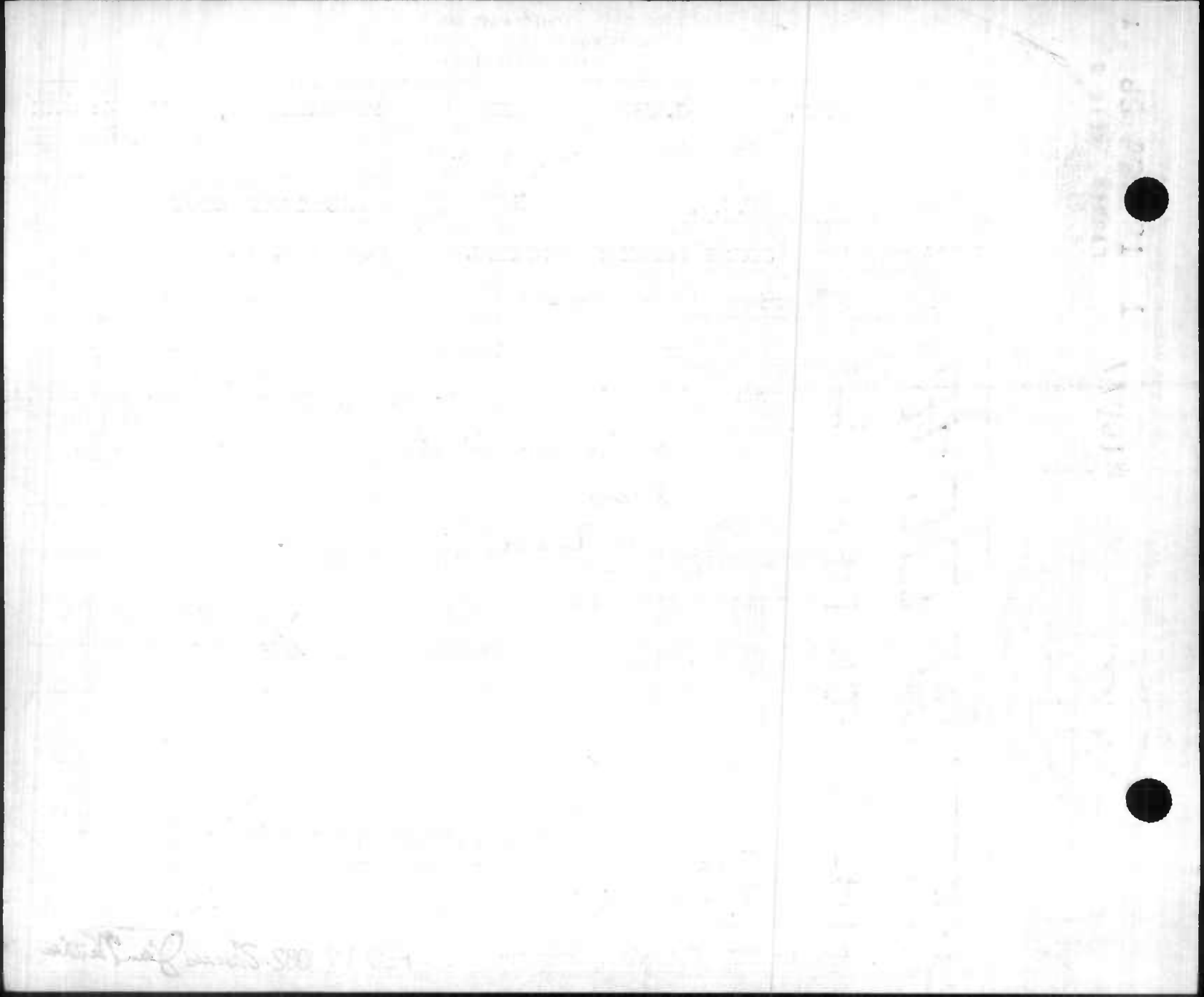
BP

DHMH-16 50M 1/81
(VRA 15, 4)

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 2 0 3 7 1 3

| | | | |
|--|--|--|--|
| 1. FOR STATE REGISTRAR | | REG. NO. | |
| 1. DECEASED NAME
(TYPE OR PRINT)
NEIL GERALD FARREN | | 2a. DATE OF DEATH
MONTH DAY YEAR
FEBRUARY 16, 1982 | |
| 3. SEX
Male | | 2b. HOUR
4:04AM | |
| 4. RACE
Caucasian | | 5. DATE OF BIRTH
MONTH DAY YEAR
Aug. 1 1932 | |
| 6. AGE (IN YEARS LAST BIRTHDAY)
49 | | 7. IF UNDER 1 YEAR
MONTHS DAYS HOURS MIN. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
New York | | 7b. CITIZEN OF WHAT COUNTRY?
U.S.A. | |
| 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
BALTIMORE CITY MD. | |
| 10. CITY OR TOWN OF DEATH
Baltimore City | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
JOHNS HOPKINS HOSPITAL | |
| 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
Bank Executive | | 12b. KIND OF BUSINESS OR INDUSTRY
Banking | |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)
13a. STATE Maryland 13b. COUNTY Harford 13c. CITY OR TOWN Joppatowne | | 13d. INSIDE CITY LIMITS?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> 13e. STREET ADDRESS
703 Ferguson Road | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
Gerald Farren | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
Dorothy Schumacher | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES UNKNOWN) YES Korean | | 16b. SOCIAL SECURITY NO.
070-24-1120 | |
| 17. INFORMANT
703 Ferguson Road
Mrs. Helen Farren Joppa, Maryland 21085 | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a) and (b). PART 1. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>Cardiopulmonary Arrest</u>
5739
DUE TO, OR AS A CONSEQUENCE OF (b) <u>Spasms</u>
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost
DUE TO, OR AS A CONSEQUENCE OF (c) <u>Liver Disease</u> | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | |
| 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | |
| 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/> | |
| 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>2/16</u> to <u>2/16</u> , 19 <u>82</u> , that (I) (we) lost saw the deceased alive on <u>2/16</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did not) view the body after death. | | | |
| 22b. SIGNATURE
<u>Samuel J. Dwyer, M.D.</u> | | 22c. DATE SIGNED
<u>2/16/82</u> | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
<u>DR. DWYER</u> | | 22e. ADDRESS
<u>The Johns Hopkins Hospital</u> | |
| 23a. BURIAL, CREMATION, REMOVAL
REMOVAL - BURIAL | | 23b. DATE
Feb. 20, '82 | |
| 23c. NAME OF CEMETERY OR CREMATORY
St. John's Cemetery | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
Queens Queens New York | |
| 24. FUNERAL DIRECTOR
NAME ADDRESS
Howard K. McComas III Abingdon, Maryland | | 25a. DATE REC'D. BY REGISTRAR
FEB 17 1982 | |
| | | 25b. REGISTRAR'S SIGNATURE
<u>Charles Jan Nathan</u> | |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed in the hospital after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

Item 5 G 565 3/2/82 GAB

1- STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 2 0 3 / 1 4

REG. NO.

| | | | | | | | | | | |
|---|--|---|--|---|--|--|---|--|--|--|
| 1. DECEASED NAME
(TYPE OR PRINT) Stanley C Fautleroy | | | 2a. DATE OF DEATH
MONTH 2 DAY 20 YEAR 82 | | | 2b. HOUR
9:30 AM | | | | |
| 3. SEX
m | | 4. RACE
B | | 5. DATE OF BIRTH
MONTH 3 DAY 27 YEAR 21 | | 6. AGE (IN YEARS LAST BIRTHDAY)
60 YRS | | IF UNDER 1 YEAR
MONTHS DAYS | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
Md | | 7b. CITIZEN OF WHAT COUNTRY?
U.S.A | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
City MD | | | | |
| 10. CITY OR TOWN OF DEATH
BALTO | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
University Hospital | | | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE) | | 12b. KIND OF BUSINESS OR INDUSTRY | | |
| 13a. STATE
Md | | 13b. COUNTY
BALTO | | 13c. CITY OR TOWN
BALTO | | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS
2111 Walbrook Ave | | |
| 14. FATHER'S NAME
FIRST Herman MIDDLE Fautleroy LAST Fautleroy | | | | 15. MOTHER'S MAIDEN NAME
FIRST Pauline MIDDLE Curry LAST Curry | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN) | | | | 16b. SOCIAL SECURITY NO. | | 17. INFORMANT
Ida M. Fautleroy ADDRESS 2111 Walbrook Ave | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART 1. DEATH WAS CAUSED BY
IMMEDIATE CAUSE (a) cardiorespiratory arrest
2019
DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last
(b) Hodgkin's disease
DUE TO, OR AS A CONSEQUENCE OF
(c) | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: Brainstem stroke, possible sepsis | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER NOTIFY MEDICAL EXAMINER) | | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | | |
| 21d. INJURY OCCURRED
WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) lost
saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated
above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | | |
| 22b. SIGNATURE
Joan M. Bathon MD | | | | | | DEGREE
ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> | | 22c. DATE SIGNED
2/20/82 | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
Joan M. Bathon MD | | | | | | 22e. ADDRESS
Univ. Hospital | | | | |
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)
Burial | | | 23b. DATE
2/24/82 | | 23c. NAME OF CEMETERY OR CREMATORY
Mt. Rebutus Cem | | 23d. LOCATION
CITY OR TOWN BALTO COUNTY MD STATE | | | |
| 24. FUNERAL DIRECTOR
NAME Vernon R. Bailey ADDRESS 1348 N. Calhoun St | | | | | | 25a. DATE REC'D. BY REGISTRAR
FEB 23 1982 | | 25b. REGISTRAR'S SIGNATURE
Joan M. Bathon | | |

100

[Faint, mostly illegible handwritten text, possibly bleed-through from the reverse side of the page. Some words like "and", "the", "of" are visible.]

FEB 29 1985

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

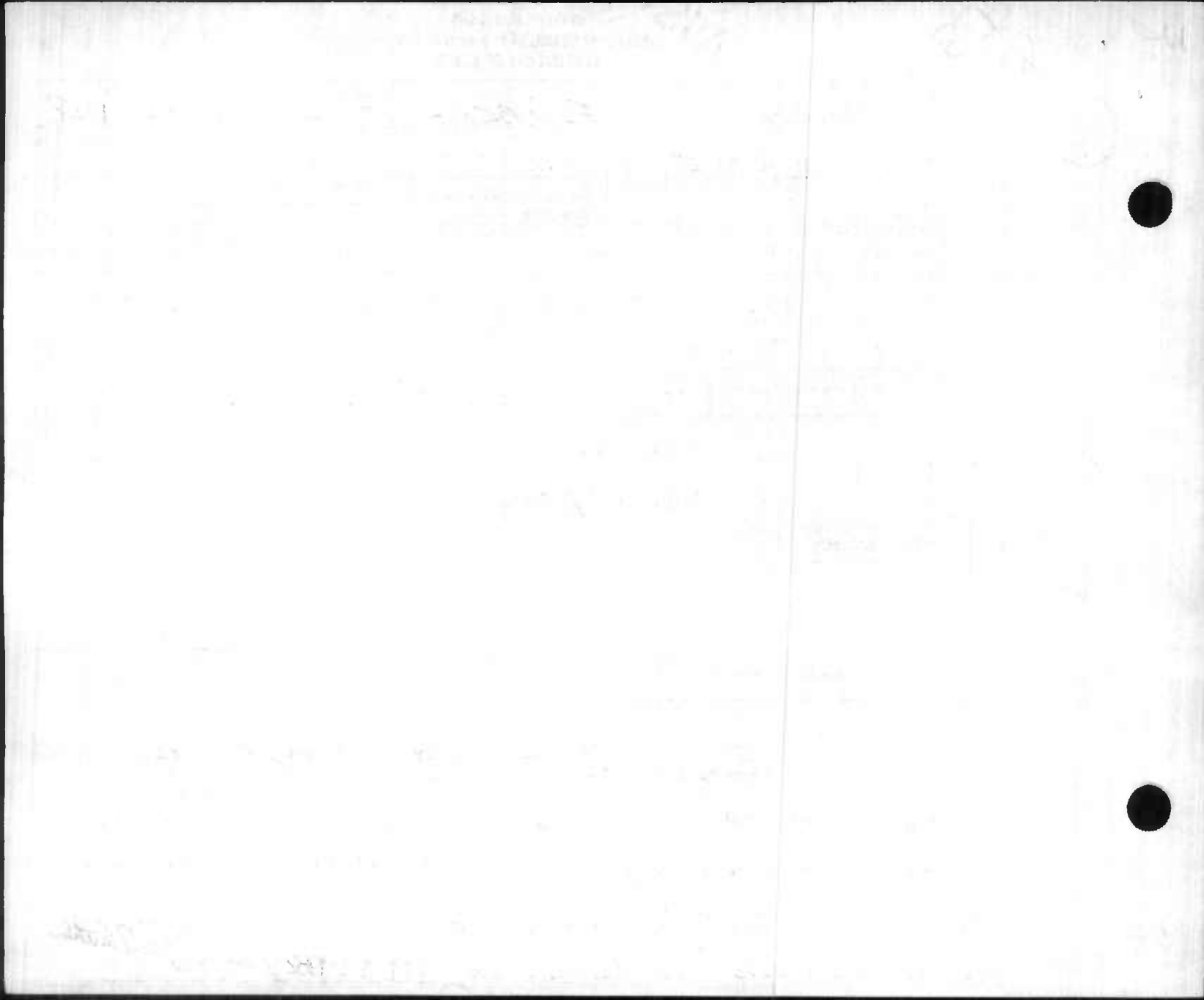
STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 2 0 3 7 1 5

1 - FOR
STATE
REGISTRAR

REG. NO.

| | | | | | | |
|---|--|---|--|--|------------------------------|--|
| 1. DECEASED NAME
(TYPE OR PRINT)
FIRST MIDDLE LAST
HERMAN FEINBERG | | | 2a. DATE OF DEATH
MONTH DAY YEAR
Feb. 5 1982 | | 2b. HOUR
1:32 P.M. | |
| 3 SEX
MALE | | 4 RACE
WHITE | | 5 DATE OF BIRTH
MONTH DAY YEAR
MAR. 15, 1895 | | |
| 6 AGE (IN YEARS LAST BIRTHDAY)
86 YRS | | 7a. UNDER 1 YEAR
MONTHS DAYS | | 7b. UNDER 24 HRS
HOURS MIN | | |
| 8 BIRTHPLACE (STATE OR FOREIGN COUNTRY)
MARYLAND | | 9a. CITIZEN OF WHAT COUNTRY?
USA | | 9b. BALTIMORE CITY OR COUNTY OF DEATH
BALTIMORE CITY MD. | | |
| 10 CITY OR TOWN OF DEATH
BALTIMORE | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
SINAI HOSPITAL | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
SALESMAN | | |
| 12b. KIND OF BUSINESS OR INDUSTRY
MEN'S CLOTHING | | 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)
13a. STATE
MARYLAND | | 13b. COUNTY
BALTO. | | |
| 13c. CITY OR TOWN
BALTIMORE | | 13d. INSIDE CITY LIMITS?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 13e. STREET ADDRESS
7015 PLYMOUTH RD. 21208 | | |
| 14 FATHER'S NAME
FIRST MIDDLE LAST
HENRY FEINBERG | | | 15 MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
RACHEL TOCKER | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
NO | | 16b. SOCIAL SECURITY NO
(IF YES, GIVE WAR OR DATES)
215 10-4992A | | 17 INFORMANT
MR. BERNARD FEINBERG
5702 OAKSHIRE RD. BALTO., MD 21209 | | |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY
IMMEDIATE CAUSE (a) Cardiac Arrest
4241
DUE TO, OR AS A CONSEQUENCE OF
(b) Arterial Insufficiency
DUE TO, OR AS A CONSEQUENCE OF
(c)
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | |
| 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | |
| 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK AT WORK | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | |
| 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | 22a. I certify that (I) (this hospital) attended the deceased from November 19 79 to February 5 19 82 , that (I) (we) lost
saw the deceased alive on February 5 19 82 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated
above, (I) (we) (did) (did not) view the body after death. | | | | |
| 22b. SIGNATURE
Jack T. Applefeld | | DEGREE
M | | 22c. DATE SIGNED
2/5/82 | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
JACK T. APPLEFELD M.D. | | 22e. ADDRESS
6615 REISTERSTOWN RD BALTO MD | | | | |
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)
BURIAL | | 23b. DATE
FEB 7 1982 | | 23c. NAME OF CEMETERY OR CREMATORY
CHICKS AMUND | | |
| 23d. LOCATION
CITY OR TOWN COUNTY STATE
BALTIMORE MARYLAND | | 24 FUNERAL DIRECTOR
NAME ADDRESS
SOL LEVINSON & BROS - 6010 REISTERSTOWN RD | | | | |
| 25a. DATE REC'D. BY REGISTRAR | | 25b. REGISTRAR
FEB 11 1982 | | | | |



STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 2 0 3 / 1 6

| | | | |
|---|---|--|---|
| 1. FOR STATE REGISTRAR | | REG. NO. | |
| 1. DECEASED NAME
(TYPE OR PRINT) | | 2a. DATE OF DEATH | |
| PAULINE F. FELL | | 02 26 82 0135 AM | |
| 3. SEX | 4. RACE | 5. DATE OF BIRTH | 6. AGE (IN YEARS LAST BIRTHDAY) |
| Female | White | July 26 1914 | 67 YRS |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) | 7b. CITIZEN OF WHAT COUNTRY? | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 9. BALTIMORE CITY OR COUNTY OF DEATH |
| Md. | U.S.A. | | BALTIMORE CITY MD. |
| 10. CITY OR TOWN OF DEATH | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | 12b. KIND OF BUSINESS OR INDUSTRY |
| Baltimore | JOHNS HOPKINS HOSPITAL | Salesperson | Candy Co. |
| 13a. STATE | | 13b. COUNTY | 13c. CITY OR TOWN |
| Md. | - | Baltimore | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |
| 14. FATHER'S NAME | | 15. MOTHER'S MAIDEN NAME | |
| Joseph Zeleny | | Mary - | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) | | 16b. SOCIAL SECURITY NO. | |
| no | | 820-03-2265 | |
| 17. INFORMANT | | ADDRESS | |
| Wm. T. Fell (son) | | same address | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| IMMEDIATE CAUSE (a) <u>Cardiopulmonary arrest</u> | | | 60 min |
| DUE TO, OR AS A CONSEQUENCE OF (b) <u>massive gastrointestinal bleeding</u> | | | 70 min |
| DUE TO, OR AS A CONSEQUENCE OF (c) <u>duodenal ulceration (endoscopy proven)</u> | | | ? years |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <u>none</u> | | | |
| 19a. DATE OF OPERATION | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | 20a. AUTOPSY? | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? |
| N/A | N/A | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 21a. CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER) | 21b. TIME OF INJURY | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | |
| N/A | HOUR A.M. MONTH DAY YEAR
P.M. N/A 19 | N/A | |
| 21d. INJURY OCCURRED | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | 21f. LOCATION | CITY OR TOWN COUNTY STATE |
| WHILE AT WORK <input type="checkbox"/> NOT AT WORK <input checked="" type="checkbox"/> | N/A | N/A | N/A |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>2/23</u> 19 <u>82</u> , to <u>2/26</u> 19 <u>82</u> , that (I) (we) last saw the deceased alive on <u>2/26</u> 19 <u>82</u> , and that (I) (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | |
| 22b. SIGNATURE | | DEGREE | 22c. DATE SIGNED |
| Lawrence E. Widman | | MD | 2/26/82 |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) | | 22e. ADDRESS | |
| LAWRENCE WIDMAN | | JOHNS HOPKINS HOSPITAL | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) | 23b. DATE | 23c. NAME OF CEMETERY OR CREMATORY | 23d. LOCATION |
| Burial | 3/1/82 | Holy Redeemer | Balto. COUNTY STATE |
| 24. FUNERAL DIRECTOR'S NAME | | 25a. DATE REC'D. BY REGISTRAR | 25b. REGISTRAR'S SIGNATURE |
| Sennetnek Funeral Home, Inc. | | MAR 1 1982 | James J. Nathan |
| 3331 Brehms Lane, Baltimore, Md. 21213 | | | |

11/10/50

RECEIVED

NOV 10 1950

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

8 2 0 3 7 1 7

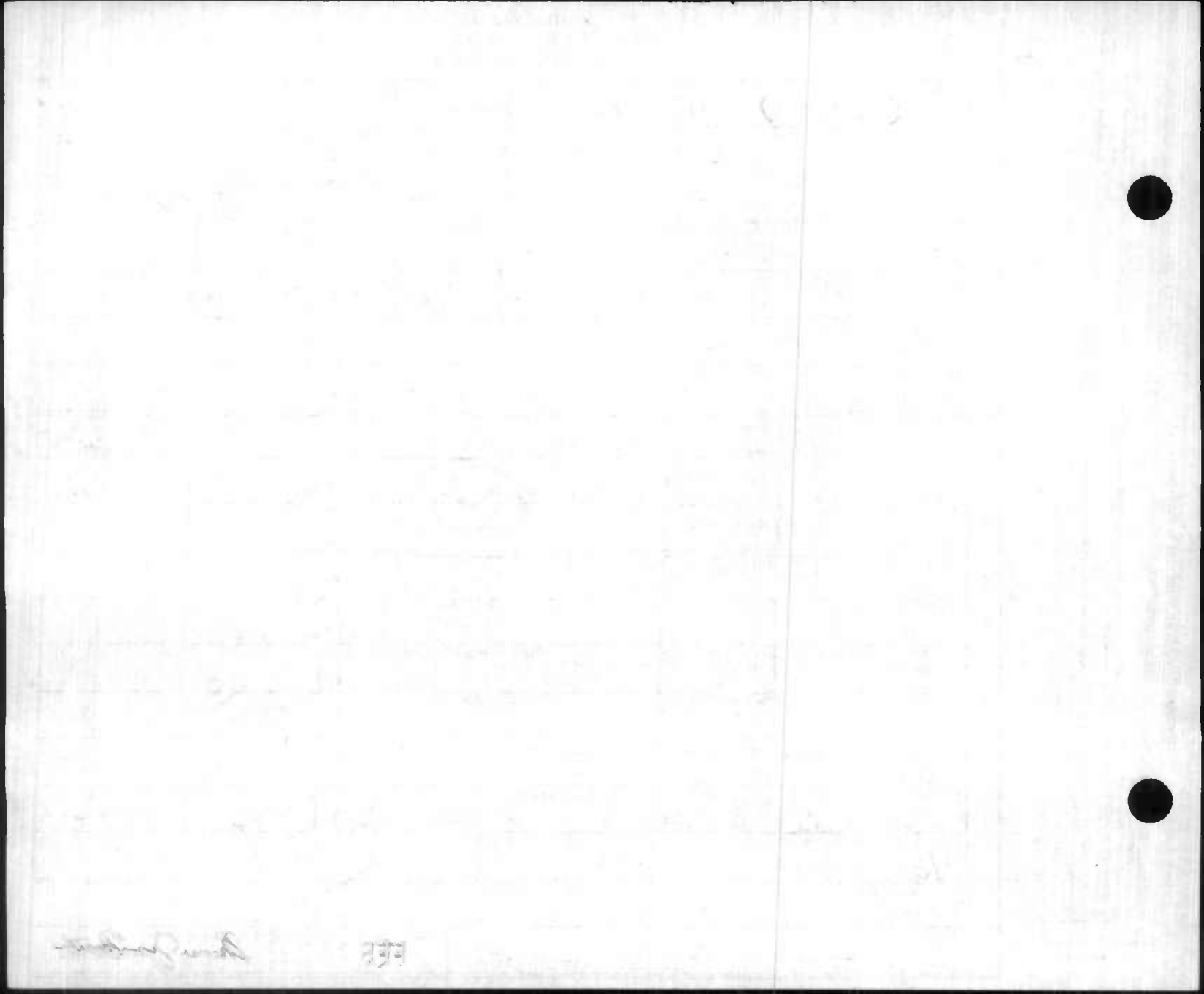
1- FOR
STATE
REGISTRAR

| | | | | | |
|---|---|---|---|--|--|
| 1. DECEASED NAME
(TYPE OR PRINT) GLADIS (GLADYS) M. FERGUSON | | | 2a. DATE OF DEATH MONTH DAY YEAR
2 21 82 | | 2b. HOUR
4:45 A |
| 3. SEX
Female | 4. RACE
Black | 5. DATE OF BIRTH
10 25 12 | 6. AGE (IN YEARS LAST BIRTHDAY)
69 | | IF UNDER 1 YEAR
MONTHS DAYS
IF UNDER 24 HRS
HOURS MIN. |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
MD | 7b. CITIZEN OF WHAT COUNTRY?
USA | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 9. BALTIMORE CITY OR COUNTY OF DEATH
City MD. | | |
| 10. CITY OR TOWN OF DEATH
Baltimore | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
North Charles General | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE) | | 12b. KIND OF BUSINESS OR INDUSTRY |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) | | | | | |
| 13a. STATE
MD | 13b. COUNTY | 13c. CITY OR TOWN
Baltimore | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | 13e. STREET ADDRESS
2015 E. 30th St. | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
John Fergusson | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
Sarah | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)
No | | 16b. SOCIAL SECURITY NO.
218-18-2513 | 17. INFORMANT ADDRESS
Deborah Jackson 5103 Conant Way | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) SEPSIS
7070
DUE TO, OR AS A CONSEQUENCE OF
(b) INFECTED DEUBITUS
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO, OR AS A CONSEQUENCE OF
(c)
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
sev. 8-10
sev. days - | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a):
CVA | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input type="checkbox"/> | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2) | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK AT WORK | | 21e. PLACE OF INJURY
(AT HOME STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | |
| 22a. I certify that (I) (this hospital) attended the deceased from 2/8 , 19 82 , to 2/20 , 19 82 , that (I) (we) last saw the deceased alive on 2/20 , 19 82 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | |
| 22b. SIGNATURE
Veneranda G. Barnes | | DEGREE
MD | | 22c. DATE SIGNED
2/21/82 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
VENERANDA G. BARNES | | 22e. ADDRESS
NORTH CHARLES GEN HOSP | | | |
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)
Burial | 23b. DATE
2/26/82 | 23c. NAME OF CEMETERY OR CREMATORY
Eastview Mem. Pk | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
Baltimore Co. MD | |
| 24. FUNERAL DIRECTOR
NAME
Wm. C. March F/H | | ADDRESS
1101 E. North Ave. | | 25a. DATE REC'D. BY REGISTRAR 25b. REGISTRAR'S SIGNATURE
FEB 23 1982 | |

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 4 may be retained by the hospital or attending physician.

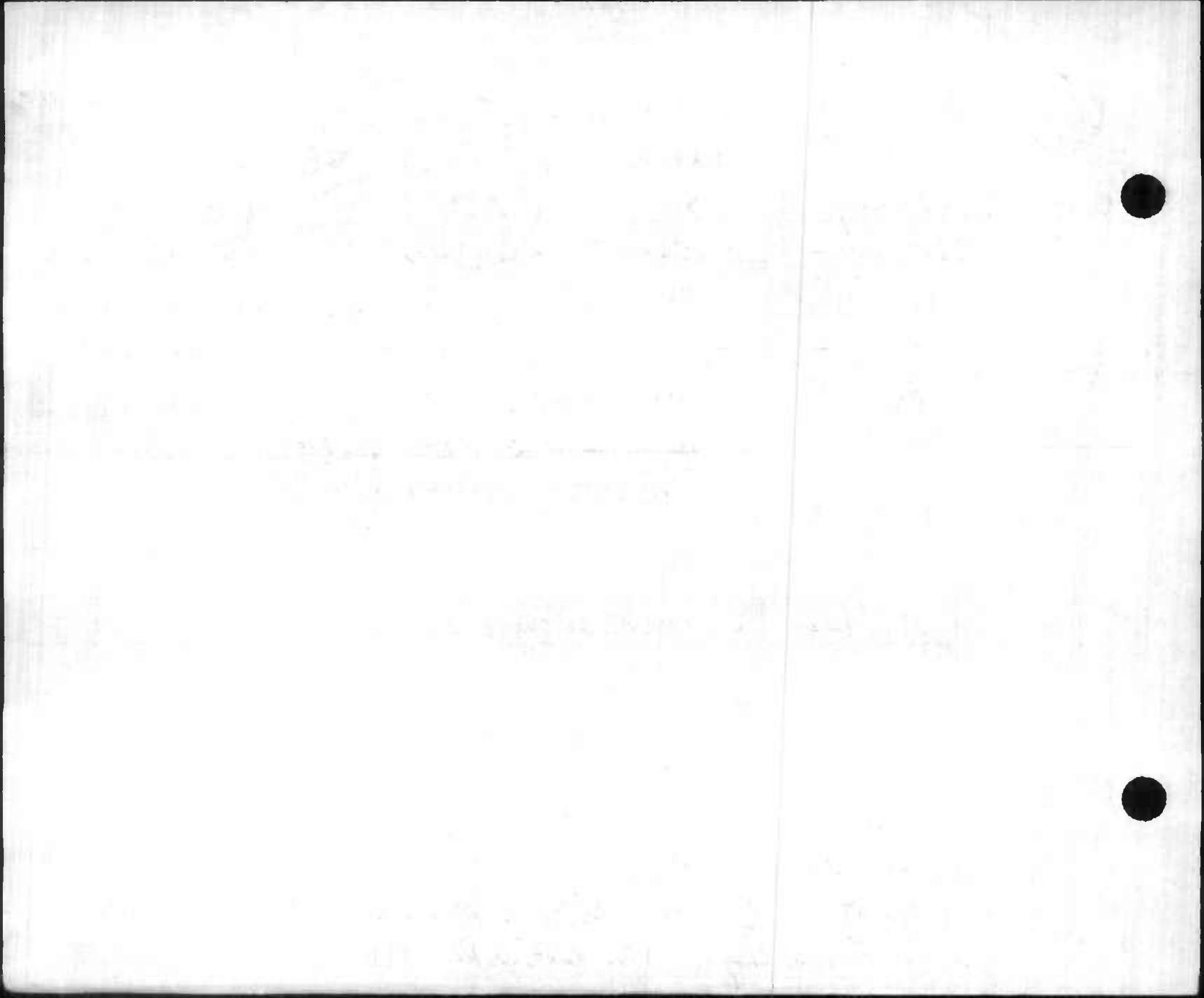
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

FOR
1 - STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

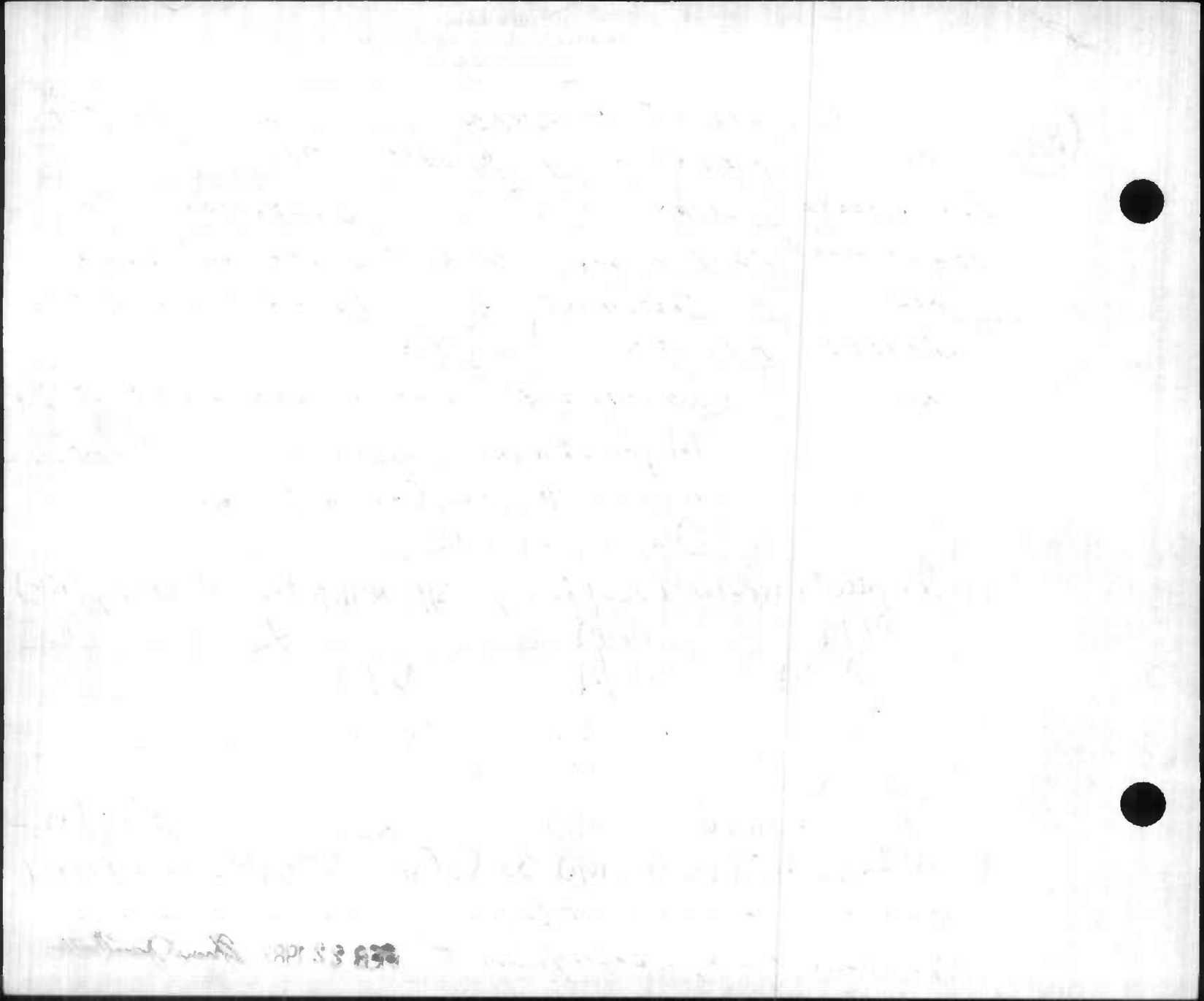
| | | | | | |
|--|---|---|---|--|--|
| 1. DECEASED NAME
(TYPE OR PRINT)
ERICH W FINDEISEN | | | 2a. DATE OF DEATH
MONTH DAY YEAR
2/17/82 | | 2b. HOUR
M
5:07 PM |
| 3. SEX
M | 4. RACE
White | 5. DATE OF BIRTH
MONTH DAY YEAR
2 10 16 | 6. AGE (IN YEARS LAST BIRTHDAY)
66 YRS. | | IF UNDER 1 YEAR
MONTHS DAYS
IF UNDER 72 HRS
HOURS MIN. |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
GERMANY | 7b. CITIZEN OF WHAT COUNTRY?
USA | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 9. BALTIMORE CITY OR COUNTY OF DEATH
BALTIMORE CITY MD. | | |
| 10. CITY OR TOWN OF DEATH
BALTIMORE | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
UNIVERSITY of MARYLAND | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
RETIRED | | 12b. KIND OF BUSINESS OR INDUSTRY
GRAYMAR CO |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)
13a. STATE MD 13b. COUNTY BALTO 13c. CITY OR TOWN Pikesville | | 13d. INSIDE CITY LIMITS?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | 13e. STREET ADDRESS
6517 WOODBRIDGE CIRCLE | | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
SELMA FINDEISEN | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
NO | 16b. SOCIAL SECURITY NO.
(IF YES, GIVE WAR OR DATES)
214 40 6927 | 17. INFORMANT
Family Records | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART 1. DEATH WAS CAUSED BY:
4100 IMMEDIATE CAUSE (a) MASSIVE MYOCARDIAL INFARCT
DUE TO, OR AS A SEQUENCE OF (b) CORONARY ARTERY DISEASE
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.
DUE TO, OR AS A CONSEQUENCE OF (c) | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1. | | | | | |
| 19a. DATE OF OPERATION
2/17/82 | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED
CORONARY ARTERY DISEASE | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input type="checkbox"/> | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | |
| 21d. INJURY OCCURRED
WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY
(AT HOME STREET FACTORY OFFICE FARM ETC) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | |
| 22a. I certify that (I) (this hospital) attended the deceased from 2/15/82 to 2/17/82, that (I) (we) lost
saw the deceased alive on 2/15/82, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated
above, (I) (we) (did) (did not) view the body after death. | | | | | |
| 22b. SIGNATURE
LUIS A. NAZARIO MD | | DEGREE
MD | | 22c. DATE SIGNED
2/17/82 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
LUIS ANTONIO NAZARIO MD | | 22e. ADDRESS
22 GREEN ST - BALTIMORE, MD | | | |
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)
CREMATION | | 23b. DATE
2/22/82 | 23c. NAME OF CEMETERY OR CREMATORY
Westview Memorial | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
BALTO MD |
| 24. FUNERAL DIRECTOR
NAME
EVANS FUNERAL Chapel 8800 Harford Rd | | 25a. DATE REC'D BY REGISTRAR
FEB 26 1982 | | 25b. REGISTRAR'S SIGNATURE
James J. [Signature] | |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
(IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.)

| STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH | | | | | | | | | | REG. NO. | | | |
|---|--|---|--|---|--|--|--|--|--|---|--|---|--|
| 1. DECEASED NAME
(TYPE OR PRINT)
FIRST MIDDLE LAST
CECIL D. FISHER | | | | | | | | | | 2a. DATE OF DEATH
MONTH DAY YEAR
2 18 81 | | 2b. HOUR ³⁰
12 P M | |
| 3. SEX
M | | 4. RACE
NAGRO | | 5. DATE OF BIRTH
MONTH DAY YEAR
4 3 1910 | | 6. AGE (IN YEARS LAST BIRTHDAY)
71 | | IF UNDER 1 YEAR
MONTHS DAYS HOURS MIN. | | 9 UNDER 72 HRS. | | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
LANCASTER PA | | 7b. CITIZEN OF WHAT COUNTRY?
USA | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
BALTIMORE CITY MD. | | | | | | | |
| 10. CITY OR TOWN OF DEATH
BALTIMORE | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
1618 N FULTON AVE | | | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
CUSTODIAN | | 12b. KIND OF BUSINESS OR INDUSTRY
BANK | | | | | |
| 13a. STATE
MD | | 13b. COUNTY
BALTIMORE | | 13c. CITY OR TOWN
BALTIMORE | | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS
1618 N FULTON AVE | | | | | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
JAMES FISHER | | | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
W. H. H. B | | | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
NO | | 16b. SOCIAL SECURITY NO.
(IF YES, GIVE WAR OR DATES)
220-01-1624 | | 17. INFORMANT
ADDRESS
VIOL ET FISHER 1618 N FULTON AVE | | | | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY
IMMEDIATE CAUSE (a) Myocardial Infarction
2500
DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b) Arteriosclerotic Cardiac Disease
DUE TO, OR AS A CONSEQUENCE OF
(c) Diabetes Mellitus | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
Sudden | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I
Periphereal Vascular Insufficiency, Sp Amputation Right Leg (Rk) | | | | | | | | | | | | | |
| 19a. DATE OF OPERATION
N/A | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED
N/A | | | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | | | | |
| 21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH
(IF EITHER NOTIFIED MEDICAL EXAMINER)
N/A | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
N/A | | 21c. HOW INJURY OCCURRED
(ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART II)
N/A | | 21d. INJURY OCCURRED
WHILE AT WORK <input type="checkbox"/> WHILE AT HOME <input checked="" type="checkbox"/>
N/A | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)
N/A | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE
N/A | | | |
| 22. I certify that (1) this hospital attended the deceased from January 28 1982 to Feb 18 1982 , that (1) (we) lost the deceased alive on January 28 1982 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (2) (we) (did not) view the body after death. | | | | | | | | | | | | | |
| 22a. SIGNATURE
Alfonso H. Janowski | | | | DEGREE
MD | | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | 22c. DATE SIGNED
2/19/82 | | | | | |
| 22b. PHYSICIAN'S NAME (TYPE OR PRINT)
Alfonso H. Janowski, MD | | | | 22e. ADDRESS
22 So Greene ST Baltimore, Md 21201 | | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL
(TYPE)
BURIAL | | 23b. DATE
2/22/82 | | 23c. NAME OF CEMETERY OR CREMATORY
MT CALVARY | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
BALTO MD 21225 | | | | | | | |
| 24. FUNERAL DIRECTOR
NAME
Manfred P. Stanger | | | | ADDRESS
6587 Gilman St | | 25a. DATE REC'D BY REGISTRAR
FEB 22 1982 | | 25b. REGISTRAR'S SIGNATURE
James J. [Signature] | | | | | |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the Registrar, Office of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH | | | | 8 2 0 3 7 2 0 | | | |
|---|--|---|--|--|--|--|--|
| FOR STATE REGISTRAR | | | | REG. NO. | | | |
| 1. DECEASED NAME (TYPE OR PRINT)
FIRST MIDDLE LAST
John Edward Flayhart | | | | 2a. DATE OF DEATH
MONTH DAY YEAR
February 25, 1982 | | 2b. HOUR
7:30 A | |
| 3 SEX
Male | | 4 RACE
White | | 5. DATE OF BIRTH
MONTH DAY YEAR
Oct. 22, 1909^R | | 6 AGE (IN YEARS LAST BIRTHDAY)
72
YRS. MONTHS DAYS HOURS MIN. | |
| 7a BIRTHPLACE (STATE OR FOREIGN COUNTRY)
Maryland | | 7b CITIZEN OF WHAT COUNTRY?
U.S.A. | | 8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9 BALTIMORE CITY OR COUNTY OF DEATH
Baltimore City
MD | |
| 10 CITY OR TOWN OF DEATH
Baltimore | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
1011 W. 37th Street | | 12a USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
Maintenance | | 12b. KIND OF BUSINESS OR INDUSTRY
Balto. City | |
| 13a STATE
Maryland | | 13b. COUNTY
Baltimore | | 13c. CITY OR TOWN
Baltimore | | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 14 FATHER'S NAME
FIRST MIDDLE LAST
John Flayhart | | | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
Anna Kamper | | | |
| 16a WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
No | | 16b SOCIAL SECURITY NO.
(IF YES, GIVE WAR OR DATES)
216 14 4130 | | 17. INFORMANT
Irene Flayhart | | ADDRESS
Same | |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART 1. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Cause of lung
1629
DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last
(b) _____
DUE TO, OR AS A CONSEQUENCE OF
(c) _____
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
? | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: _____ | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK AT WORK | | 21e. PLACE OF INJURY
(AT HOME STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 6/29/81 , 19 81 , to 7/1 , 19 81 , that (I) (we) lost above, the deceased alive on 7/1/81 , 19 81 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death. | | | | | | | |
| 22b. SIGNATURE
Sylvan D. Goldberg MD | | | | DEGREE
MD | | 22c. DATE SIGNED
2/26/82 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
Dr. Sylvan D. Goldberg | | | | 22e. ADDRESS
Medical Arts Building Baltimore, Md. | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)
Burial | | 23b. DATE
1 March 1982 | | 23c. NAME OF CEMETERY OR CREMATORY
Parkwood Cemetery | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
Parkville, Balto. Co. Md. | |
| 24 FUNERAL DIRECTOR
NAME ADDRESS
Burgess Funeral Home 3631 Falls Rd. 21211 | | | | 25a. DATE REC'D. BY REGISTRAR
MAR 2 1982 | | | |

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January 1, 1934

January 1, 1934

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. It is to be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

FOR
STATE
REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 2 0 3 / 2 1

REG. NO.

| | | | | | | | | | |
|--|--|--|--|---|--|--|--|--|--|
| 1. DECEASED NAME
(TYPE OR PRINT)
CARL FLECK | | | 2a. DATE OF DEATH
MONTH DAY YEAR
02 26 82 | | | 2b. HOUR
1:15 AM | | | |
| 3. SEX
MALE | | 4. RACE
WHITE | | 5. DATE OF BIRTH
MONTH DAY YEAR
09 24 17 | | 6. AGE (IN YEARS LAST BIRTHDAY)
64 YRS. | | 7. IF UNDER 1 YEAR
MONTHS DAYS HOURS MIN.
00 00 00 00 | |
| 8. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
MARYLAND | | 7b. CITIZEN OF WHAT COUNTRY?
U.S.A. | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
BALTIMORE CITY MD. | | | |
| 10. CITY OR TOWN OF DEATH
BALTIMORE | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
ST. AGNES HOSPITAL | | | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
WELDER | | 12b. KIND OF BUSINESS OR INDUSTRY
MARYLAND | |
| 13a. STATE
MARYLAND | | 13b. COUNTY
BALTIMORE | | 13c. CITY OR TOWN
CATONSVILLE | | 13d. INSIDE CITY LIMITS?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 13e. STREET ADDRESS
SHIPBUILDING 10 ARKLA COURT, 21228 | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
HENRY FLECK | | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
ANNA BRAUN | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
NO | | 16b. SOCIAL SECURITY NO.
215-09-9728 | | 17. INFORMANT ADDRESS
EUGENIA R. FLECK 10 ARKLA COURT, 21228 | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY
IMMEDIATE CAUSE (a) Cardiorespiratory arrest
1629
DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b) Terminal Lung ca E metastases
DUE TO, OR AS A CONSEQUENCE OF
(c) _____
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | | | | | | | | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) _____ | | | | | | | | | |
| 19a. DATE OF OPERATION
— | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED
— | | | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
— P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)
— | | | | | |
| 21d. INJURY OCCURRED
WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY
(AT HOME STREET, FACTORY, OFFICE, FARM, ETC.)
— | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE
— — — — — | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 2/23/82 19 82 , to 2/26/82 19 82 , that (I) (we) last saw the deceased alive on 2/25 19 82 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | |
| 22b. SIGNATURE
Amar N. Sarwal DEGREE MD | | | | | | ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> | | 22c. DATE SIGNED
2/26/82 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
AMAR N. SARWAL | | | | 22e. ADDRESS
St. Agnes Hospital Baltimore Md | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)
BURIAL | | 23b. DATE
03-01-82 | | 23c. NAME OF CEMETERY OR CREMATORY
LOUDON PARK | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
BALTIMORE CITY MARYLAND | | | |
| 24. FUNERAL DIRECTOR
NAME ADDRESS
HUBBARD FUNERAL HOME, INC. 4107 WILKENS AVE. | | | | 25a. DATE REC'D. BY REGISTRAR
MAR 1 1982 | | 25b. REGISTRAR'S SIGNATURE
Ernesco Jan Nathan | | | |

Continued from p. 1

From a distance of about 100 yds. the water is very shallow and the bottom is composed of fine sand and shells. The water is very clear and the bottom is very smooth.

Continued from p. 1

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP

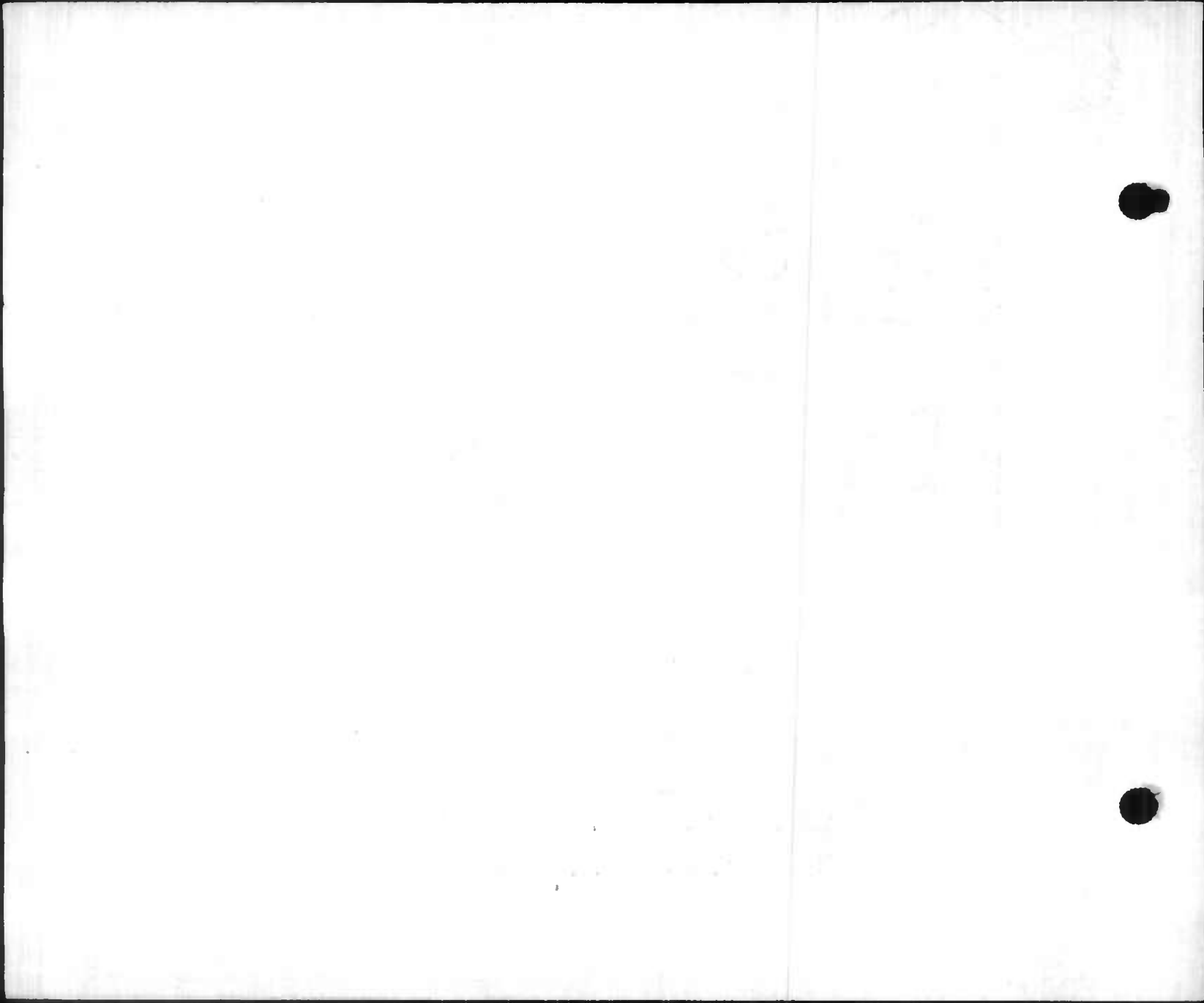
DHMH-17
(VR A15 ME (5))
15M 2/80

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

1- FOR
STATE
REGISTRAR

| | | | | | |
|--|------------------|---|---|---|---|
| 1. DECEASED NAME
(TYPE OR PRINT)
Ladell V. Flood | | | 2a. DATE KNOWN OF DEATH
ESTIMATED
2 10 1982 | | 2b. HOUR
M |
| 3. SEX
Female | 4. RACE
Black | 5. DATE OF BIRTH
MONTH DAY YEAR
6 15 42 | 6. AGE (IN YEARS)
LAST BIRTHDAY
39 YRS. | IF UNDER 1 YR.
MONTHS DAYS HOURS MIN. | IF UNDER 24 HRS. |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
D.C. | | 7b. CITIZEN OF WHAT COUNTRY?
USA | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/> | |
| 9. BALTIMORE CITY OR COUNTY OF DEATH
Baltimore City, MD | | 10. CITY OR TOWN OF DEATH
Baltimore | | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
University Hospital - STU | |
| 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | | 12b. KIND OF BUSINESS OR INDUSTRY | | 13a. STATE
MD | |
| 13b. COUNTY | | 13c. CITY OR TOWN
Baltimore | | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 13e. STREET ADDRESS
4231 Thayer Court | | 14. FATHER'S NAME
FIRST MIDDLE LAST
Martin J. York | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
Ozzie Miller | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO, OR UNKNOWN)
No | | 16b. SOCIAL SECURITY NO.
215-40-2880 | | 17. INFORMANT ADDRESS
Ovetta Goodson 4231 Thayer Ct. | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Blunt injury to Pelvis
8147
Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.
(b) DUE TO, OR AS A CONSEQUENCE OF
(c) DUE TO, OR AS A CONSEQUENCE OF
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | | | | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1. (a) | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | | | 20. AUTOPSY?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH | | 21b. TIME OF INJURY
HOUR MONTH DAY YEAR
9:45 P.M. 2 9 1982 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)
pedestrian struck by auto | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)
road | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE
New Ordinance Rd. near Blades Lane, Anne Arundel Co., Md. | |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> . | | | | | |
| ACTUAL SIGNATURE
Virginia L. Dolan | | TITLE (SPECIFY)
Assistant | | DATE SIGNED
2-10-82 | |
| EXAMINER'S NAME
(TYPE OR PRINT)
Virginia L. Dolan, M.D. | | ADDRESS
111 Penn Street | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)
Burial | | 23b. DATE
2/13/82 | | 23c. NAME OF CEMETERY OR CREMATORY
Cedar Hill Cem. | |
| 23d. LOCATION
CITY OR TOWN
Baltimore | | 23e. COUNTY
Co. | | 23f. STATE
MD | |
| 24. FUNERAL DIRECTOR
NAME
Wm. C. March F/H | | ADDRESS
1101 E. North Ave. | | 25a. DATE REC'D. BY REGISTRAR
FEB 11 1982 | |
| 25b. REGISTRAR'S SIGNATURE
James J. Martin | | | | | |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

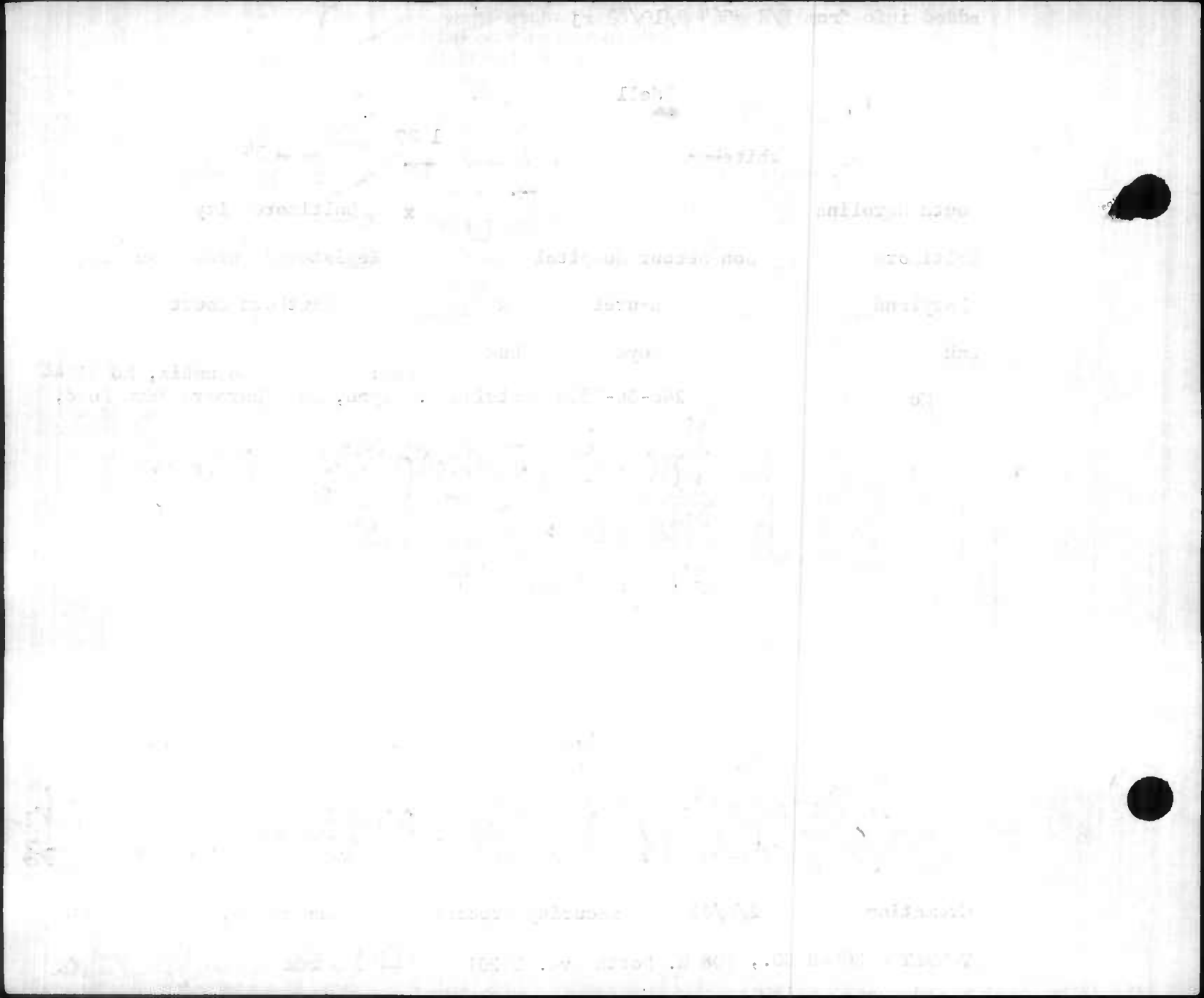
added info from F/H g564 2/10/82 g3
STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 2 0 3 7 2 3

REG. NO.

| | | | | | | | | | | |
|--|--|---|--|---|---|--|--|--|--|--|
| 1. DECEASED NAME
(TYPE OR PRINT) FRANCIS J. FLYNN | | | 2a. DATE OF DEATH
MONTH DAY YEAR
FEB. 4 / 1982 | | | 2b. HOUR
MIN. 4:50 P.M. | | | | |
| 3. SEX
Female | | 4. RACE
White | | 5. DATE OF BIRTH
MONTH DAY YEAR
12 / 2 / 1927 | | 6. AGE (IN YEARS LAST BIRTHDAY)
YRS. 56 54 | | 7. UNDER 1 YEAR
MONTHS DAYS
56 54 | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
South Carolina | | 7b. CITIZEN OF WHAT COUNTRY?
USA | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
Baltimore City MD. | | | | |
| 10. CITY OR TOWN OF DEATH
Baltimore | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
Bon Secour Hospital | | | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
Registered Nurse | | 12b. KIND OF BUSINESS OR INDUSTRY
Nursing | | |
| 13a. USUAL RESIDENCE (IF NOT IN HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)
STATE Maryland COUNTY P.G. | | | 13c. CITY OR TOWN
Laurel | | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS
Hawthorn Court | | | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
Unk Boyd | | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
Unk | | | 17. INFORMANT Son: ADDRESS: Columbia, MD 21044
Patrick C. Flynn, 5456 Harpers Farm Road, | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
No | | | 16b. SOCIAL SECURITY NO.
248-36-1505 | | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART 1. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Hypoxic - Hypoglycemic
3030
DUE TO, OR AS A CONSEQUENCE OF metabolic Encephalopathy
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last:
(b) post cardiovascular arrest
DUE TO, OR AS A CONSEQUENCE OF Chronic Ethanolism
(c) Chronic Ethanolism | | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:
Pneumonia | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | | |
| 21d. INJURY OCCURRED
WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from Jan 1 , 19 82 , to Feb 4 , 19 82 , that (I) (we) lost saw the deceased alive on Feb 4 , 19 82 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (If we) (I did) (did not) view the body after death. | | | | | | | | | | |
| 22b. SIGNATURE
Bernardo D. Gonzalez Jr. | | | DEGREE MD
ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | | 22c. DATE SIGNED
Feb. 4/82 | | | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
BERNARDO D. GONZALEZ JR. | | | 22e. ADDRESS
200 W. Fayette St. Baltimore, Md 21203 | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)
Cremation | | | 23b. DATE
2/6/82 | | 23c. NAME OF CEMETERY OR CREMATORY
Security Process | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
Catonsville, MD | | | |
| 24. FUNERAL DIRECTOR
NAME
STEWART & MOWEN CO., 108 W. North Ave. 21201 | | | | | 25a. DATE REC'D. BY REGISTRAR
FEB 10 1982 | | | | | |
| | | | | | 25b. REGISTRAR'S SIGNATURE
Charles J. Nathan | | | | | |

BP



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be completed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, pages 1 and 2 should be detached for use as the burial/transit permit. Then please remove to the Bureau of Vital Records, State Dept. of Health and Mental Hygiene, for filing with the State Dept. of Health and Mental Hygiene. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

| STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH | | | | | | | | | | 8 2 0 3 7 2 4 | |
|--|--|---|--|---|--|---|--|--|--|---------------|--|
| 1. FOR STATE REGISTRAR | | | | | | | | | | REG. NO. | |
| 1. DECEASED NAME
(TYPE OR PRINT)
HILLDA H. FONTANAZZA | | | | | | 2a. DATE OF DEATH
MONTH DAY YEAR
FEBRUARY 15, 1982 | | 2b. HOUR
11:35AM | | | |
| 3. SEX
Female | | 4. RACE
White | | 5. DATE OF BIRTH
MONTH DAY YEAR
Dec. 16, 1956 | | 6. AGE (IN YEARS (LAST BIRTHDAY))
25 | | 7. IF UNDER 1 YEAR
MONTHS DAYS HOURS MIN. | | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
Maryland | | 7b. CITIZEN OF WHAT COUNTRY?
U.S.A. | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
BALTIMORE CITY MD. | | | | | |
| 10. CITY OR TOWN OF DEATH
Baltimore | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
THE JOHNS HOPKINS HOSPITAL | | | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
Housewife | | 12b. KIND OF BUSINESS OR INDUSTRY | | | |
| 13a. STATE
Maryland | | 13b. COUNTY
Baltimore | | 13c. CITY OR TOWN
Baltimore | | 13d. INSIDE CITY LIMITS?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 13e. STREET ADDRESS
1825 Darrich Drive | | | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
Donald Henry | | | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
June Hunt | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
NO | | 16b. SOCIAL SECURITY NO.
(IF YES, GIVE WAR OR DATES)
218-72-7907 | | 17. INFORMANT
ADDRESS
Franklin J. Fontanazza 1825 Darrich Drive
Baltimore, Md. | | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART 1. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>disseminated cytomegalovirus infection</u>
2050
DUE TO, OR AS A CONSEQUENCE OF
(b) <u>bone marrow transplantation</u>
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO, OR AS A CONSEQUENCE OF
(c) <u>acute myelogenous leukemia</u>
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
1 week
6 weeks
2 years | | | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | | | | | |
| 21d. INJURY OCCURRED
WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | | | | | |
| 22. I certify that (I) (this hospital) attended the deceased from <u>2/15</u> , 19 <u>82</u> to <u>2/15</u> , 19 <u>82</u> not (I) (we) lost
saw the deceased alive on <u>2/15</u> , 19 <u>82</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated
above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | | | |
| 22a. SIGNATURE
Mark J. Rattan | | | | DEGREE
M.D. | | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> | | 22c. DATE SIGNED
2/15/82 | | | |
| 22b. PHYSICIAN'S NAME (TYPE OR PRINT)
MARK J. RATAN | | | | 22e. ADDRESS
JOHNS HOPKINS | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)
Burial | | 23b. DATE
Feb. 18, 1982 | | 23c. NAME OF CEMETERY OR CREMATORY
Parkwood Cemetery | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
Baltimore Maryland | | | | | |
| 24. FUNERAL DIRECTOR
Leonard J. Ruck, Inc. Baltimore, Maryland | | | | 25a. DATE REC'D. BY REGISTRAR
FEB 16 1982 | | 25b. REGISTRAR'S SIGNATURE
Thomas J. Ruck | | | | | |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

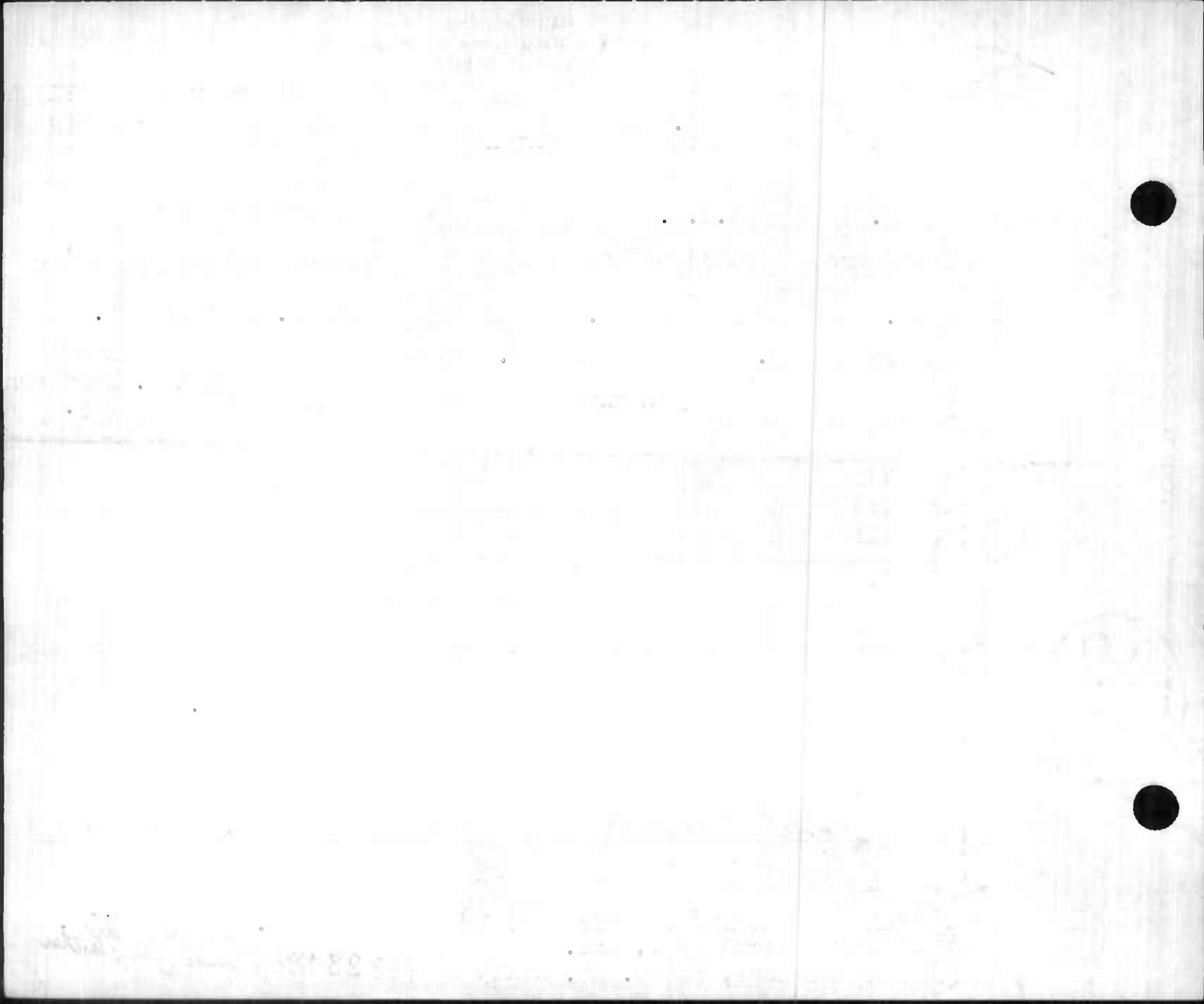
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 2 0 3 / 2 5

| | | | | | | | |
|---|--|---|--|---|--|--|--|
| 1- FOR STATE REGISTRAR | | 1 DECEASED NAME
(TYPE OR PRINT) Henry C. Foos | | 2a DATE OF DEATH 2-21-82 YEAR MONTH DAY | | 2b HOURS 4:25 MIN. | |
| 3 SEX male | | 4 RACE white | | 5 DATE OF BIRTH 7-17-93 MONTH DAY YEAR | | 6 AGE (IN YEARS (LAST BIRTHDAY)) 88 YRS. MONTHS DAYS HOURS MIN. | |
| 7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) Md. | | 7b CITIZEN OF WHAT COUNTRY? U.S.A. | | 8 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9 BALTIMORE CITY OR COUNTY OF DEATH Baltimore City MD. | |
| 10 CITY OR TOWN OF DEATH Baltimore | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Baltimore City Hospital | | 12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Factory Worker | | 12b KIND OF BUSINESS OR INDUSTRY Cork & Seal | |
| 13a STATE Md. | | 13b COUNTY Balto. | | 13c CITY OR TOWN Balto. | | 13d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 14 FATHER'S NAME FIRST Henry MIDDLE C. LAST Foos | | 15. MOTHER'S MAIDEN NAME FIRST M. Magdaline MIDDLE Kollner | | 13e STREET ADDRESS 529 N. Robinson St. | | | |
| 16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) no | | 16b SOCIAL SECURITY NO. 215-07-1568 | | 17 INFORMANT ADDRESS 1683 E. Northern Pkwy. | | | |
| 18 CAUSE OF DEATH: Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) cardiopulmonary arrest
4275
DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last:
(b) _____
DUE TO, OR AS A CONSEQUENCE OF
(c) _____
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | | | | | | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: _____ | | | | | | | |
| 19a DATE OF OPERATION | | 19b CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER) | | 21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) | | | |
| 21d INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK | | 21e PLACE OF INJURY (AT HOME STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f LOCATION STREET CITY OR TOWN COUNTY STATE | | | |
| 22a I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) lost saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | |
| 22b SIGNATURE Robert T. Schweitzer | | DEGREE MD | | ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> | | 22c DATE SIGNED 2/21/82 | |
| 22d PHYSICIAN'S NAME (TYPE OR PRINT) Robert T. Schweitzer | | 22e ADDRESS Balto. City Hospital | | | | | |
| 23a BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | | 23b DATE 2/23/82 | | 23c NAME OF CEMETERY OR CREMATORY Oak Lawn Cemetery | | 23d LOCATION CITY OR TOWN Balto. COUNTY Md. STATE | |
| 24 FUNERAL HOME NAME Sopruncnek Funeral Home, Inc. ADDRESS 3331 Brehms Lane, Balto. Md. 21213 | | | | 25a DATE REC'D. BY REGISTRAR FEB 23 1982 REGISTRAR SIGNATURE James J. [Signature] | | | |



STATE OF MARYLAND

DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 2 0 3 / 2 6

REG. NO.

1- FOR
STATE
REGISTRAR

| | | | | | |
|--|---|---|--|---|---|
| 1. DECEASED NAME
(TYPE OR PRINT) FIRST MIDDLE LAST
ARTHUR GARFIELD FOOTE | | | 2a. DATE OF DEATH MONTH DAY YEAR
2 24 82 | | 2b. HOUR
8:05 AM |
| 3. SEX
Male | 4. RACE
Black | 5. DATE OF BIRTH MONTH DAY YEAR
8 - 12 1905 | | 6. AGE (IN YEARS LAST BIRTHDAY)
76 YRS. | IF UNDER 1 YEAR
MONTHS DAYS HOURS MIN. |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
md | 7b. CITIZEN OF WHAT COUNTRY?
USA | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
Baltimore City MD. | |
| 10. CITY OR TOWN OF DEATH
Baltimore | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
S. Baltimore General Hospital | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
Retired | | 12b. KIND OF BUSINESS OR INDUSTRY
- |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)
13a. STATE
MD. | 13b. COUNTY
BALT. | 13c. CITY OR TOWN
SEVERN | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | 13e. STREET ADDRESS
1807 Circle Road, Severn md | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
Unkn | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
Unkn | | ADDRESS
Unkn | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
Unkn | 16b. SOCIAL SECURITY NO.
Unkn | 17. INFORMANT
ASHANKMAN MD S.BALT. HOSPITAL | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART 1. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) CESSATION OF RESPIRATIONS
7991
DUE TO, OR AS A CONSEQUENCE OF
(b) RESPIRATORY ARREST
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.
(c) - | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
36 hours |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (c) | | | | | |
| 19a. DATE OF OPERATION | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input type="checkbox"/> | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/> | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 2/22 , 19 82 , to 2/24 , 19 82 , that (I) (we) lost
saw the deceased alive on 2/24 , 19 82 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated
above, (I) (we) (did) (did not) view the body after death. | | | | | |
| 22b. SIGNATURE
Andrew Shankman MD | DEGREE
MD | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | 22c. DATE SIGNED
2-24-82 | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
Andrew Shankman, MD | | 22e. ADDRESS
S. BALT. GENERAL HOSPITAL | | | |
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)
Burial | 23b. DATE
3-3-1982 | 23c. NAME OF CEMETERY OR CREMATORY
Chow Memorial | 23d. LOCATION
CITY OR TOWN COUNTY STATE
OWENSVILLE BALT. MD. | 25. DATE RECEIVED BY REGISTRAR
MAR 8 1982 | |
| 24. FUNERAL DIRECTOR
NAME
C. E. Hicks III | | ADDRESS
1922 ANNAPOLIS, MD | | 25. REGISTRAR'S SIGNATURE
Handwritten Signature | |

MEDICAL CERTIFICATION

11

STATE OF NEW YORK
IN SENATE
JANUARY 13, 1903

REPORT
OF THE
COMMISSIONER OF THE LAND OFFICE
IN RESPONSE TO A RESOLUTION
PASSED BY THE SENATE
JANUARY 13, 1903
ALBANY:
J.B. LIPPINCOTT & CO. PRINTERS
1903

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 must be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

DHMH - 16 50M 1/81
(VIA 15, 4)

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 2 0 3 7 2 7

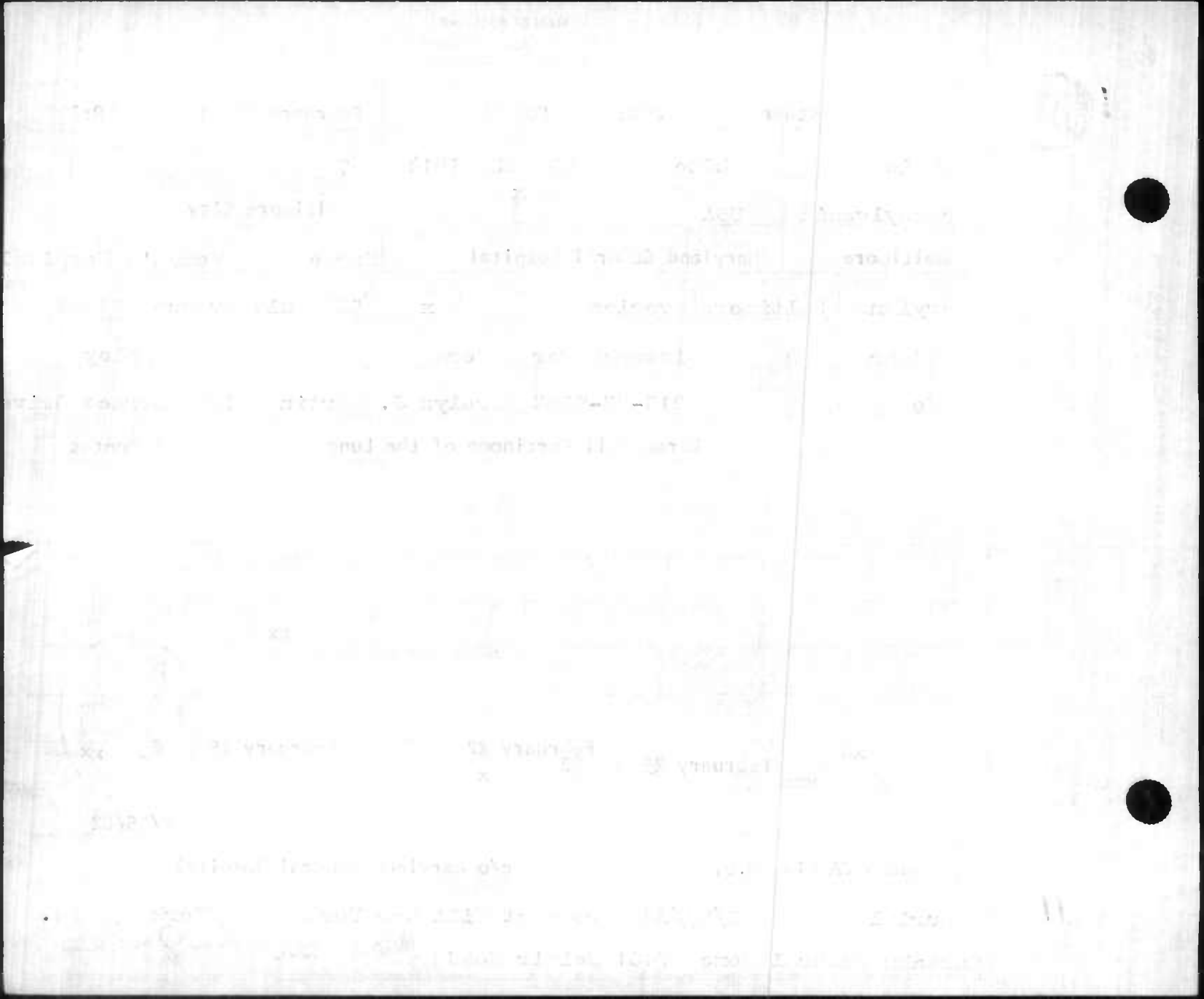
1. FOR
STATE
REGISTRAR

REG. NO.

| | | | | | |
|---|---|---|---|--|--|
| 1. DECEASED NAME
(TYPE OR PRINT)
Esther N.ata FORBES | | | 2a. DATE OF DEATH
MONTH DAY YEAR
February 25, 1982 | | 2b. HOUR
9:30a M |
| 3. SEX
Female | 4. RACE
White | 5. DATE OF BIRTH
MONTH DAY YEAR
03 08 1914 | | 6. AGE (IN YEARS LAST BIRTHDAY)
67 YRS | IF UNDER 1 YEAR
MONTHS DAYS
IF UNDER 24 HRS
HOURS MIN. |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
Pennsylvania | 7b. CITIZEN OF WHAT COUNTRY?
USA | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
Baltimore City MD. | |
| 10. CITY OR TOWN OF DEATH
Baltimore | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
Maryland General Hospital | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
Nurse | | 12b. KIND OF BUSINESS OR INDUSTRY
Women's Hospital |
| 13a. STATE
Maryland | 13b. COUNTY
Baltimore | 13c. CITY OR TOWN
Overlea | 13d. INSIDE CITY LIMITS?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | 13e. STREET ADDRESS
526 Dale Avenue 21206 | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
Edward D Dittenhaffer | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
Cora E Eppley | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
No | | 16b. SOCIAL SECURITY NO.
215-22-9504 | | 17. INFORMANT
ADDRESS
Carolyn J. Martin 5158 Terrace Drive | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART 1. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Large Cell Carcinoma of the Lung
1629
DUE TO, OR AS A CONSEQUENCE OF
(b) _____
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO, OR AS A CONSEQUENCE OF
(c) _____ | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
2 Months |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | |
| 22a. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from February 22, 19 82 , to February 25, 19 82 , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on February 25, 19 82 , and that in <input checked="" type="checkbox"/> (my) (our) opinion death occurred on the date and hour and from the causes stated above, <input checked="" type="checkbox"/> (we) (did) <input checked="" type="checkbox"/> (not) view the body after death. | | | | | |
| 22b. SIGNATURE
Huang-Ta Lin | | DEGREE
M.D. | | 22c. DATE SIGNED
2/25/82 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
Huang-TA Lin, M.D. | | 22e. ADDRESS
c/o Maryland General Hospital | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)
Burial | 23b. DATE
2/27/82 | 23c. NAME OF CEMETERY OR CREMATORY
Prospect Hill Cem | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
York York Pa. | |
| 24. FUNERAL DIRECTOR
NAME
Lassahn Funeral Home | | ADDRESS
7401 Belair Road | | 25a. RECEIVED BY REGISTRAR
MAR 2 1982 | 25b. REGISTRAR'S SIGNATURE
<i>[Signature]</i> |

MEDICAL CERTIFICATION

BP 11



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. It may be returned by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 2 0 3 / 2 8

| | | | |
|---|--|---|--|
| 1- FOR STATE REGISTRAR | | REG. NO. | |
| 1. DECEASED NAME (TYPE OR PRINT)
Edith Edith MIDDLE Lorraine LAST Ford | | 2a. DATE OF DEATH MONTH DAY YEAR
2/4/82 2 4 82 6:40 AM | |
| 3. SEX
Female
FEMALE | 4. RACE
Caucasian
WHITE | 5. DATE OF BIRTH MONTH DAY YEAR
11/02/06 | 6. AGE (IN YEARS LAST BIRTHDAY)
75 75 YRS. |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
Maryland | 7b. CITIZEN OF WHAT COUNTRY?
USA | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 9. BALTIMORE CITY OR COUNTY OF DEATH
Baltimore City MD. |
| 10. CITY OR TOWN OF DEATH
Baltimore | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
St. Agnes Hospital | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)
Housewife | 12b. KIND OF BUSINESS OR INDUSTRY
Home |
| 13a. STATE
Maryland | 13b. COUNTY
---- | 13c. CITY OR TOWN
Baltimore | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |
| 14. FATHER'S NAME FIRST MIDDLE LAST
Thomas J. Armacost | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST
Minnie Ronnenberg | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)
No | |
| 16b. SOCIAL SECURITY NO.
N/A | 17. INFORMANT
Lorraine F. Fennema | ADDRESS 143 Shetland Cir. Reisterstown, Md. | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART 1. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>Respiratory failure 2° to COPD</u>
4960
DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (b), stating the underlying cause lost.
(b) _____
DUE TO, OR AS A CONSEQUENCE OF
(c) _____ | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1.1a
<u>ASCVD, Cor pulmonale, Recurrent pneumonitis</u> | | | |
| 19a. DATE OF OPERATION | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER NOTIFY MEDICAL EXAMINER) | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/> | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | 21f. LOCATION
STREET
CITY OR TOWN
COUNTY
STATE | |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>12-19</u> , 19 <u>81</u> , to <u>2-4</u> , 19 <u>82</u> that (I) (we) lost saw the deceased alive on <u>2-3</u> , 19 <u>82</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | |
| 22b. SIGNATURE
<u>M. H. S.</u> | DEGREE | ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> | 22c. DATE SIGNED
2/4/82 |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
<u>A. Methew</u> | 22e. ADDRESS
<u>St. Agnes Hospital, Baltimore.</u> | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)
Burial | 23b. DATE
2/6/82 | 23c. NAME OF CEMETERY OR CREMATORY
Loudon Park | 23d. LOCATION
CITY OR TOWN
COUNTY
STATE
Baltimore City, Maryland |
| 24. FUNERAL DIRECTOR
NAME
MacNabb Funeral Home | | 25a. DATE REC'D. BY REGISTRAR
FEB 9 1982 | |
| ADDRESS
Catonsville, Md. | | 25b. REGISTRAR'S SIGNATURE
<u>James J. Hetherington</u> | |

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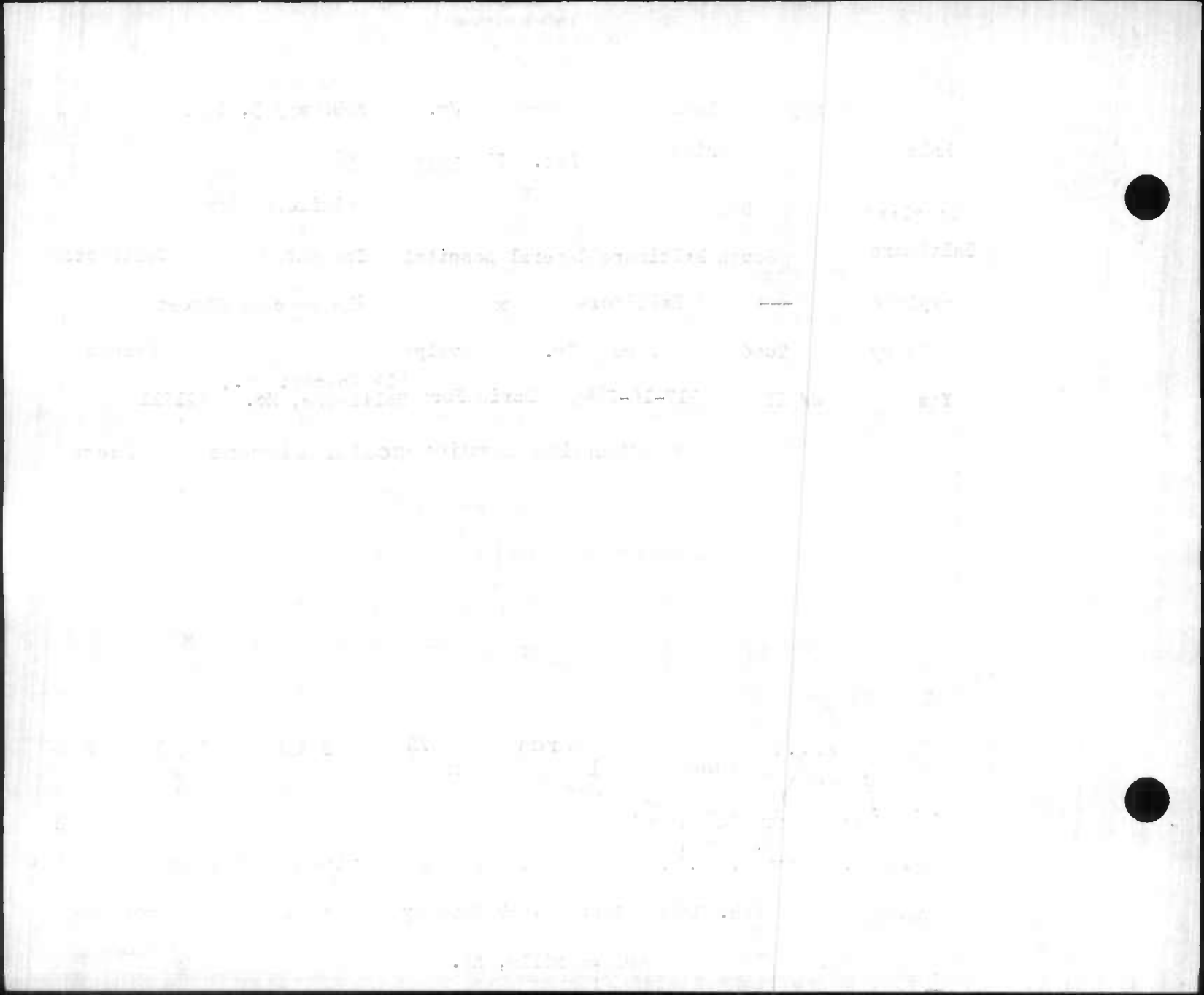
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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. It may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH | | | | 8 2 0 3 7 2 9 | | | |
|---|--|---|--|---|--|--|--|
| 1 - FOR
STATE
REGISTRAR | | | | REG. NO. | | | |
| 1. DECEASED NAME (TYPE OR PRINT)
FIRST MIDDLE LAST
Henry Todd Ford Jr. | | | | 2a. DATE OF DEATH MONTH DAY YEAR
February 5, 1982 | | 2b. HOUR
3 p m | |
| 3. SEX
Male | | 4. RACE
White | | 5. DATE OF BIRTH MONTH DAY YEAR
Dec. 20 1923 | | 6. AGE (IN YEARS LAST BIRTHDAY) YRS. MONTHS DAYS
58 | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
Maryland | | 7b. CITIZEN OF WHAT COUNTRY?
USA | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
Baltimore City MD. | |
| 10. CITY OR TOWN OF DEATH
Baltimore | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
South Baltimore General Hospital | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)
Carpenter | | 12b. KIND OF BUSINESS OR INDUSTRY
Contractor | |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) STATE
Maryland | | | | 13b. COUNTY
Baltimore | | 13c. CITY OR TOWN
Baltimore | |
| 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | | 13e. STREET ADDRESS
414 Fawcett Street | | | |
| 14. FATHER'S NAME FIRST MIDDLE LAST
Henry Todd Ford Sr. | | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST
Evelyn Barnes | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)
Yes | | 16b. SOCIAL SECURITY NO.
WW II 217-16-2849 | | 17. INFORMANT ADDRESS
Doris Ford Baltimore, Md. 21211 | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Hypertensive Cardiovascular Disease
DUE TO, OR AS A CONSEQUENCE OF (b) _____
DUE TO, OR AS A CONSEQUENCE OF (c) _____
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
Years | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | |
| 22a. I certify that I (the physician) attended the deceased from March 1975 to 6 Feb 1982 , that <input checked="" type="checkbox"/> (we) lost saw the deceased alive on 9 June 1981 , and that in (my) <input checked="" type="checkbox"/> opinion death occurred on the date and hour and from the causes stated above, (I) <input checked="" type="checkbox"/> did not view the body after death. | | | | | | | |
| 22b. SIGNATURE
<i>Marc I. Leavey</i> | | | | DEGREE
ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | 22c. DATE SIGNED
6 Feb 82 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
Marc I. Leavey, M.D. | | | | 22e. ADDRESS
7600 Osler Drive, Baltimore MD 21204 | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)
Burial | | 23b. DATE
Feb. 9/82 | | 23c. NAME OF CEMETERY OR CREMATORY
Loudon Park Centery | | 23d. LOCATION CITY OR TOWN COUNTY STATE
Baltimore Maryland | |
| 24. FUNERAL DIRECTOR NAME
<i>H. J. Echhardt</i> | | | | ADDRESS
Owings Mills, Md. | | 25. DATE RECD. BY REGISTRAR
Feb 9 1982 | |
| | | | | 25b. REGISTRAR'S SIGNATURE
<i>James J. [Signature]</i> | | | |



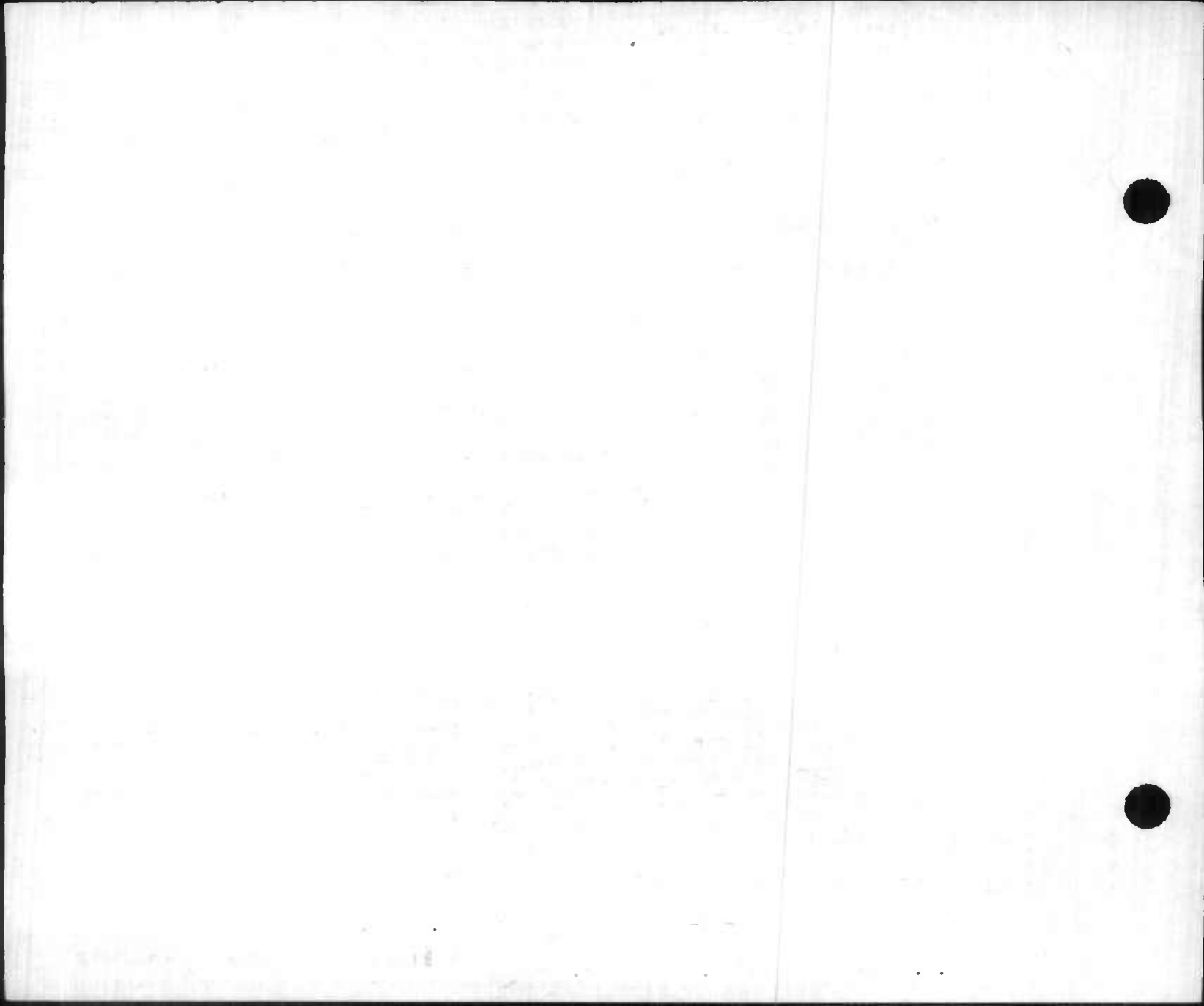
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 27 hours of death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

| Items 21a.-21f.&22a. | | | | STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE | | 8 2 0 3 7 3 0 | |
|--|--|--|--|--|--|--|--|
| 1. STATE REGISTRAR | | | | CERTIFICATE OF DEATH | | | |
| 1. DECEASED NAME (TYPE OR PRINT) | | | | 2a. DATE OF DEATH | | | |
| FIRST MIDDLE LAST | | | | MONTH DAY YEAR | | | |
| James Ford | | | | 2 8 82 9 30 P M | | | |
| 3. SEX | | 4. RACE | | 5. DATE OF BIRTH | | 6. AGE (IN YEARS LAST BIRTHDAY) | |
| MALE | | BLACK | | MONTH DAY YEAR
11 27 94 | | 87 YRS | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) | | 7b. CITIZEN OF WHAT COUNTRY? | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH | |
| MARYLAND | | US | | | | Balt. City MD | |
| 10. CITY OR TOWN OF DEATH | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | | 12b. KIND OF BUSINESS OR INDUSTRY | |
| Baltimore | | PROVIDENT HOSPITAL | | RETIRED | | | |
| 13a. STATE | | | | 13b. COUNTY | | 13c. CITY OR TOWN | |
| MARYLAND | | | | BALTIMORE | | BALTIMORE | |
| 14. FATHER'S NAME | | | | 15. MOTHER'S MAIDEN NAME | | | |
| JAMES FORD | | | | KATE WATKINS | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) | | | | 16b. SOCIAL SECURITY NO. | | 17. INFORMANT ADDRESS | |
| YES | | | | | | ALEASE STOKES 3710 STRATHMORE AVE | |
| 18. CAUSE OF DEATH: Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Cardiopulmonary Arrest</u> | | | | | | | |
| 2500 DUE TO, OR AS A CONSEQUENCE OF (b) <u>Uncontrolled diabetes</u> | | | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF (c) _____ | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a) _____ | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? | |
| 1/14/82 | | Fracture Left Femur | | YES <input type="checkbox"/> NO <input type="checkbox"/> | | YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | |
| <input checked="" type="checkbox"/> | | 9:35 A.M. 1 11 82 | | Fall Injury | | | |
| 21d. INJURY OCCURRED | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION | | | |
| WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/> | | Home | | 2408 Liberty Hgts. Ave. Balto., Md. | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>1/11/82</u> to <u>2/11/82</u> , that (I) (we) last saw the deceased alive on <u>2/11/82</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | |
| 22b. SIGNATURE | | | | DEGREE | | 22c. DATE SIGNED | |
| [Signature] | | | | ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> | | 2/15/82 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) | | | | 22e. ADDRESS | | | |
| Ronald D. Miles, M.D. | | | | Provident Hosp. | | | |
| 23a. BURIAL, CREMATION, REMOVAL | | 23b. DATE | | 23c. NAME OF CEMETERY OR CREMATORY | | 23d. LOCATION | |
| BURIAL | | 2-23-82 | | CROWNSVILLE VET. CEMT. | | CITY OR TOWN COUNTY STATE | |
| 24. FUNERAL DIRECTOR | | | | 25. DATE REC'D. BY REGISTRAR | | | |
| NAME ADDRESS
E.L. PHILLIPS 1721 N. MONROE ST. | | | | FEB 25 1982 [Signature] | | | |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. It may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

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| | | | | | | |
|--|--|---|---|--|---|--|
| 1. DECEASED NAME
(TYPE OR PRINT)
FIRST MIDDLE LAST
SYLVIA FOREMAN | | | 2a. DATE OF DEATH
MONTH DAY YEAR
FEB. 6, 1982 | | 2b. HOUR
11:45 PM | |
| 3. SEX
FEMALE | | 4. RACE
WHITE | | 5. DATE OF BIRTH
MONTH DAY YEAR
FEB. 12, 1912 | | |
| 6. AGE (IN YEARS LAST BIRTHDAY)
69 YRS. | | 7. IF UNDER 1 YEAR
MONTHS DAYS | | 8. IF UNDER 24 HRS.
HOURS MIN. | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
MARYLAND | | 7b. CITIZEN OF WHAT COUNTRY?
USA | | 9. BALTIMORE CITY OR COUNTY OF DEATH
BALTIMORE CITY MD. | | |
| 10. CITY OR TOWN OF DEATH
BALTIMORE | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
SINAI HOSPITAL | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
HOUSEWIFE | | |
| 12b. KIND OF BUSINESS OR INDUSTRY
HOME | | 13a. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13b. STREET ADDRESS
6823 WILLIAMSON AVE. (21215) | | |
| 13a. STATE
MARYLAND | | 13b. COUNTY | | 13c. CITY OR TOWN
BALTIMORE | | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
BENNEY KIMMEL | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
ROSIE KARLINSKY | | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)
NO | | |
| 16b. SOCIAL SECURITY NO
214-30-6431 | | 17. INFORMANT
ADDRESS
MORRIS J. FOREMAN 6823 WILLIAMSON AVE. (21215) | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY
IMMEDIATE CAUSE (a) <u>Cardiac Arrest</u>
<u>4960</u>
DUE TO, OR AS A CONSEQUENCE OF
(b) <u>Severe COPD & Respiratory Failure</u>
DUE TO, OR AS A CONSEQUENCE OF
(c) _____
CONDITIONS, if any, which gave rise to immediate cause (a), stating the underlying cause last | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
<u>acute</u>
<u>Jan/82</u> | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | |
| 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | |
| 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | |
| 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | 22a. I certify that (I) (this hospital) attended the deceased from <u>1/8</u> 19 <u>81</u> , to <u>2/6</u> 19 <u>82</u> , that (I) (we) last saw the deceased alive on <u>2/3/82</u> 19 <u>82</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (ed) (did not) view the body after death. | | | | |
| 22b. SIGNATURE
<u>A. S. Hallens</u> M.D. | | DEGREE
<u>MD</u> | | 22c. DATE SIGNED
2/8/82 | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
EDWARD KALLENS, M.D. | | 22e. ADDRESS
6000 PARK HEIGHTS AVE. (21215) | | | | |
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)
BURIAL | | 23b. DATE
2-8-82 | | 23c. NAME OF CEMETERY OR CREMATORY
SHAAREI ZION CONG. | | |
| 23d. LOCATION
CITY OR TOWN COUNTY STATE
ROSEDALE, MD. BALTO. MD. | | 24. FUNERAL DIRECTOR
NAME SOL LEVINSON & BROS
6010 REISTERSTOWN RD. BALTIMORE, MD. (21215) | | | | |
| 25a. DATE REC'D. BY REGISTRAR
FEB 11 1982 | | 25b. REGISTRAR'S SIGNATURE
<u>Frances Jean</u> | | | | |

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Dear Sir,
I have the pleasure to inform you that
the same has been received.

Yours faithfully,
J. H. [Signature]

SPR 1

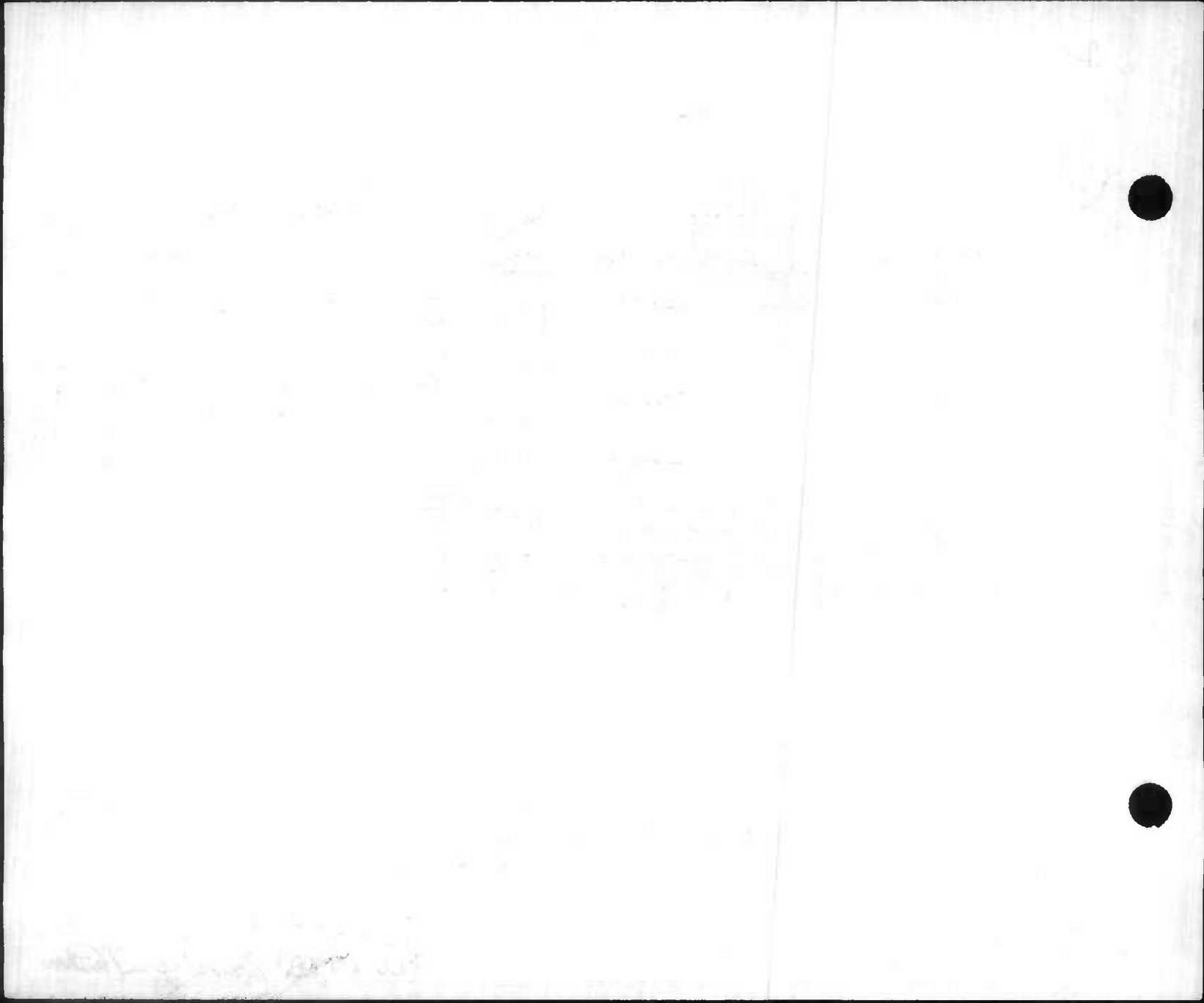
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 5 days of death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 2 0 3 7 3 2

REG. NO.

| | | | | | | | | | |
|---|--|--|---|---|--|--|--|--|--|
| 1. DECEASED NAME
(TYPE OR PRINT)
FIRST MIDDLE LAST
BERTHA Ellen FOWLER | | | 2a. DATE OF DEATH
MONTH DAY YEAR
2 13 82 | | | 2b. HOUR
8:30 A.M. | | | |
| 3. SEX
FEMALE | | 4. RACE
CAUCASIAN | | 5. DATE OF BIRTH
MONTH DAY YEAR
1 2 98 | | 6. AGE (IN YEARS LAST BIRTHDAY)
84 | | 7. IF UNDER 1 YEAR
MONTHS DAYS
IF UNDER 24 HRS.
HOURS MIN. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
Maryland | | 7b. CITIZEN OF WHAT COUNTRY?
U.S.A. | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
Baltimore City MD. | | | |
| 10. CITY OR TOWN OF DEATH
Baltimore | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
Baltimore City Hospitals | | | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
HOMEMAKER | | 12b. KIND OF BUSINESS OR INDUSTRY | |
| 13a. STATE
Maryland | | 13b. COUNTY
Balto. | | 13c. CITY OR TOWN
Dundalk | | 13d. INSIDE CITY LIMITS?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 13e. STREET ADDRESS
Dunleer Apts. 21222 | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
Frank Ruff | | | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
Virginia Unknown | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)
NO | | 16b. SOCIAL SECURITY NO.
213.18.1585A | | 17. INFORMANT
Jack T. Fowler | | ADDRESS
1314 Westburn Rd. Baltimore, Md. 21228 | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART 1. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) CARDIOPULMONARY ARREST
4100
DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.
(b) MYOCARDIAL INFARCTION, HEART FAILURE
DUE TO, OR AS A CONSEQUENCE OF
(c) 2 DAYS | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)
METASTATIC LUNG CANCER, LEFT PLEURAL EFFUSION | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | | | |
| 21d. INJURY OCCURRED
WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 2/10 , 19 82 , to 2/13 , 19 82 , that (I) (we) last saw the deceased alive on 2/13 , 19 82 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | |
| 22b. SIGNATURE
Conrad May | | | | | | DEGREE
ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> | | 22c. DATE SIGNED
2/13/82 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
CONRAD MAY | | | | 22e. ADDRESS
BALTIMORE CITY HOSPITAL | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)
Cremation | | 23b. DATE
2/15/1982 | | 23c. NAME OF CEMETERY OR CREMATORY
Green Mount Crematory | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
Baltimore Maryland | | | |
| 24. FUNERAL DIRECTOR
NAME
Walter Brooks Bradley Inc, Dundalk Md 21222 | | | | | | 25a. DATE REC'D. BY REGISTRAR
FEB 18 1982 | | 25b. REGISTRAR'S SIGNATURE
Frances Jean Nathan | |

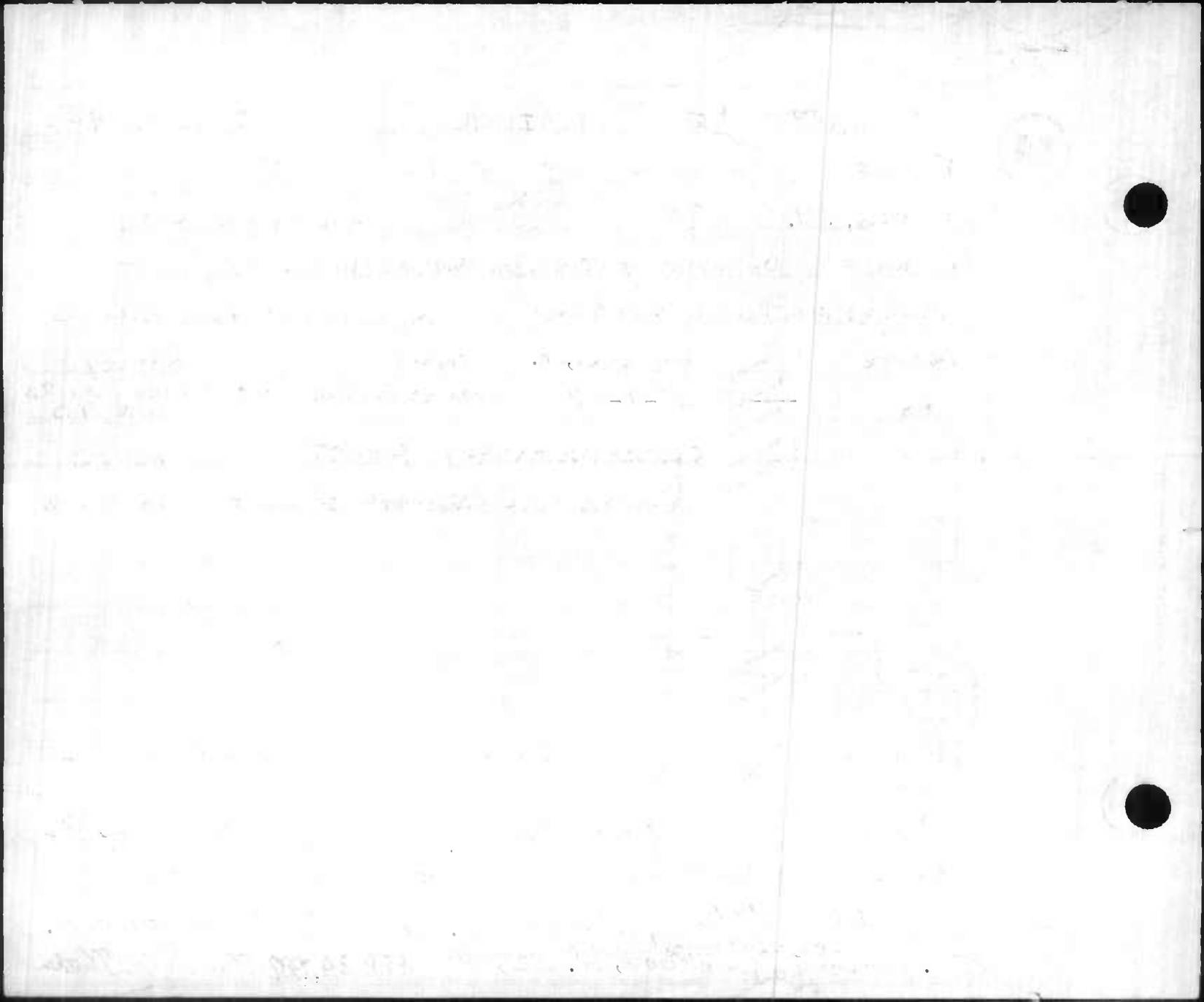


TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at 1-800-368-5858.

| STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH | | | | | | | | | | REG. NO. | |
|--|--|--|--|---|--|--|--|--|--|--|--|
| 1. FOR STATE REGISTRAR | | 1. DECEASED NAME
(TYPE OR PRINT) FIRST MIDDLE LAST
MARY E FRAILER | | | | | | 2a. DATE OF DEATH MONTH DAY YEAR
2 22 82 | | 2b. HOUR
4³⁰ A.M. | |
| 3. SEX
FEMALE | | 4. RACE
Caucasian | | 5. DATE OF BIRTH MONTH DAY YEAR
9 9 22 | | 6. AGE (IN YEARS LAST BIRTHDAY)
59 YRS. | | IF UNDER 1 YEAR MONTHS DAYS
IF UNDER 24 HRS. HOURS MIN. | | | |
| 7a. BIRTHPLACE (COUNTRY) STATE OR FOREIGN
CHICAGO, ILL. | | 7b. CITIZEN OF WHAT COUNTRY?
USA | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
BALTIMORE CITY MD. | | | | | |
| 10. CITY OR TOWN OF DEATH
BALTIMORE | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
UNIVERSITY OF MARYLAND HOSPITAL | | | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)
HOUSEWIFE | | 12b. KIND OF BUSINESS OR INDUSTRY
— | |
| 13a. STATE
MARYLAND | | 13b. COUNTY
ANNE ARUNDEL | | 13c. CITY OR TOWN
GLEN BURNIE | | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 13e. STREET ADDRESS
109 MARLEY NECK RD | | | |
| 14. FATHER'S NAME FIRST MIDDLE LAST
ARCHIE HOLMGREN JR. | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST
MARY BAILEY | | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO | | 16b. SOCIAL SECURITY NO.
215-16-6019 | | 17. INFORMANT
CHARLES FRAILER | | ADDRESS
109 MARLEY NECK RD GLEN BURNIE MD | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) CARDIO PULMONARY ARREST
1629
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost }
(b) SQUAMOUS CELL CARCINOMA OF LUNG
DUE TO, OR AS A CONSEQUENCE OF
(c) 16 MONTHS | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
MINUTES | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:
NONE | | | | | | | | | | | |
| 19a. DATE OF OPERATION
— | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED
— | | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR
19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) | | | | | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | | | | | |
| 22a. I certify that the (this hospital) attended the deceased from FEBRUARY 19 19 82 to FEBRUARY 22 19 82 , that (1) (we) lost the deceased alive on FEBRUARY 22 19 82 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (1) (we) (did) (did not) view the body after death. | | | | | | | | | | | |
| 22b. SIGNATURE
Eric S. Tannenbaum, MD | | | | | | DEGREE
MD | | ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> | | 22c. DATE SIGNED
2/22/82 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
ERIC TANNENBAUM | | | | | | 22e. ADDRESS
UNIVERSITY OF MARYLAND HOSPITAL 22 S. GREENE ST. BALT. MD. | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)
Burial | | 23b. DATE
2/24/82 | | 23c. NAME OF CEMETERY OR CREMATORY
Glen Haven Mem. Park | | 23d. LOCATION CITY OR TOWN COUNTY STATE
Glen Burnie Anne Arundel Md. | | | | | |
| 24. FUNERAL DIRECTOR (NAME)
Mc Cully Funeral Home of Brooklyn 237 E. Patapsco Avenue Baltimore, Md. 21225 | | | | | | 25a. DATE REC'D. BY REGISTRAR
FEB 24 1982 | | 25b. REGISTRAR'S SIGNATURE
Barbara Van Natten | | | |

BP



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the Registrar, Division of Health and Mental Hygiene prior to burial, cremation, or removal.

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STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

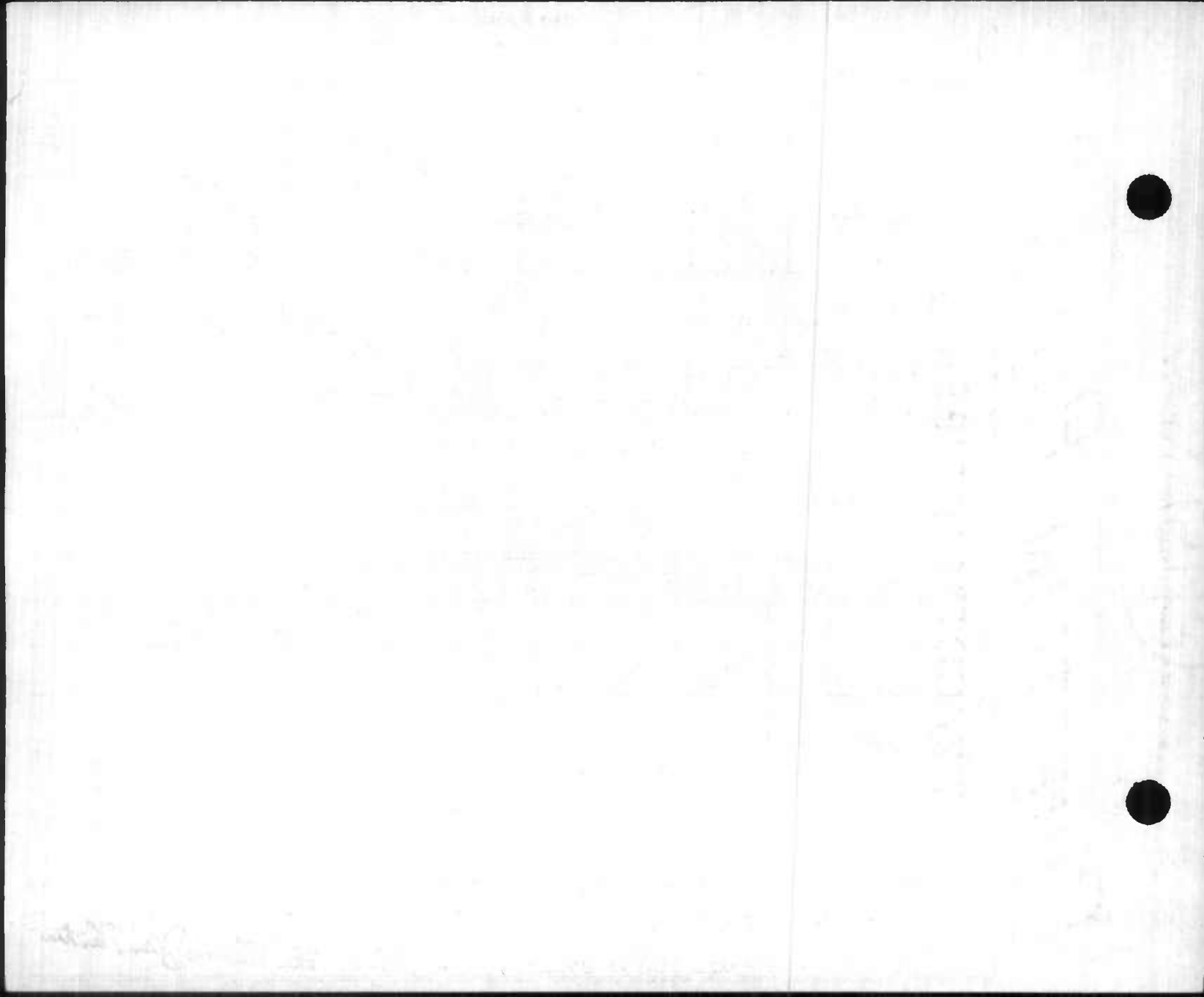
8 2 0 3 7 3 4

1- FOR
STATE
REGISTRAR

Mildred Dawson Frank

REG. NO.

| | | | | | |
|---|--|---|---|--|---|
| 1. DECEASED NAME
(TYPE OR PRINT)
FIRST MIDDLE LAST
<i>Mildred Frank</i> | | 2a. DATE OF DEATH
MONTH DAY YEAR
<i>2-27-82</i> | | 2b. HOUR
<i>11 P.M.</i> | |
| 3. SEX
<i>F</i> | 4. RACE
<i>W</i> | 5. DATE OF BIRTH
MONTH DAY YEAR
<i>2-28-96</i> | | 6. AGE (IN YEARS LAST BIRTHDAY)
YRS. MONTHS DAYS
<i>85</i> | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
<i>md.</i> | 7b. CITIZEN OF WHAT COUNTRY?
<i>U.S.A.</i> | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
<i>City</i> MD. | |
| 10. CITY OR TOWN OF DEATH
<i>Balto.</i> | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
<i>Bon Secours Hospital</i> | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
<i>retired</i> | | 12b. KIND OF BUSINESS OR INDUSTRY
<i>Housewife</i> |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) | | | | | |
| 13a. STATE
<i>md.</i> | 13b. COUNTY
<i>Balto.</i> | 13c. CITY OR TOWN
<i>Balto.</i> | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | 13e. STREET ADDRESS
<i>3330 Wilkends Ave.</i> | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
<i>Edward C. Myers</i>
<i>unavail.</i> | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
<i>Lillian C. Dawson</i>
<i>unavail.</i> | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
<i>no</i> | | 16b. SOCIAL SECURITY NO.
<i>214-74-8837</i> | | 17. INFORMANT
ADDRESS
<i>Chart - Bon Secours Hosp.</i> | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <i>CARDIO PULMONARY ARREST.</i>
<i>5698</i>
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last:
(b) <i>BOWEL PERFORATION WITH PERITONITIS</i>
(c) <i>DUE TO, OR AS A CONSEQUENCE OF</i> | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a):
<i>ARTERIOSCLEROTIC HEART DISEASE</i> | | | | | |
| 19a. DATE OF OPERATION
<i>2/23/82</i> | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED
<i>PERITONITIS</i> | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
<i>P.M. - 19</i> | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)
<i>-</i> | |
| 21d. INJURY OCCURRED
WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)
<i>-</i> | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE
<i>-</i> | |
| 22a. I certify that (I) (this hospital) attended the deceased from <i>2-5-</i> , 19 <i>82</i> , to <i>2-26-</i> , 19 <i>82</i> , that (I) (we) lost saw the deceased alive on <i>2-26-</i> , 19 <i>82</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | |
| 22b. SIGNATURE
<i>Surgit A. Julka</i> | | DEGREE
<i>M.D.</i>
ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | | 22c. DATE SIGNED
<i>2/24/82</i> |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
<i>SURGIT JULKA</i> | | 22e. ADDRESS
<i>BON SECOURS HOSPITAL.</i> | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)
<i>Cremation</i> | | 23b. DATE
<i>3/1/82</i> | | 23c. NAME OF CEMETERY OR CREMATORY
<i>Security Process</i> | |
| 23d. LOCATION
CITY OR TOWN COUNTY STATE
<i>Catonsville Baltimore Md.</i> | | | | | |
| 24. FUNERAL DIRECTOR
NAME
<i>MacNabb Funeral Home</i> | | ADDRESS
<i>Catonsville, Md.</i> | | 25a. DATE REC'D. BY REGISTRAR
<i>MAR 5 1982</i> | |
| 25b. REGISTRAR'S SIGNATURE
<i>Frances J. Nathan</i> | | | | | |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified as on page 3.

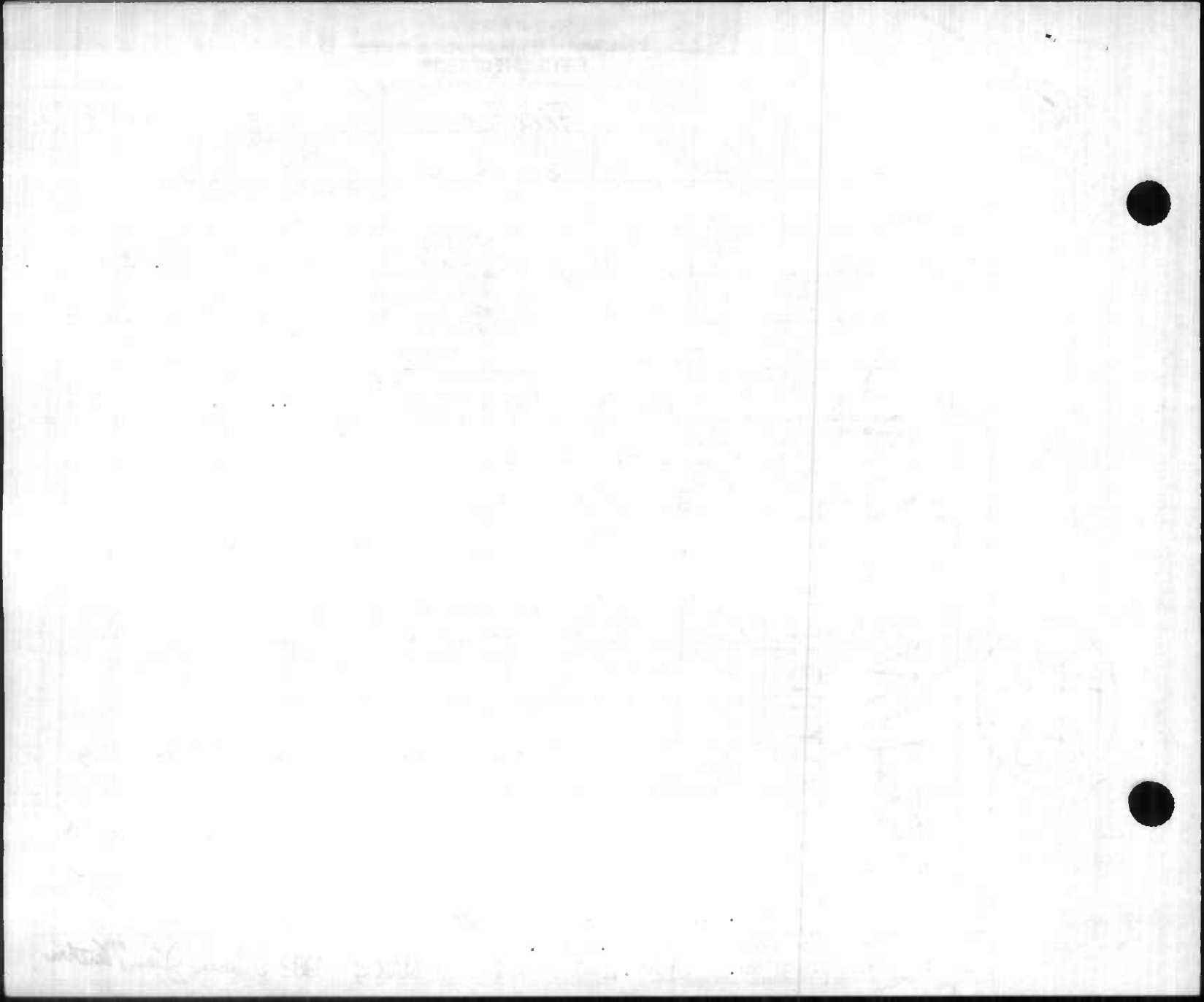
STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 2 0 3 / 3 5

FOR
STATE
REGISTRAR

REG. NO.

| | | | | | | | | | | |
|--|--|---|--|---|---|---|---|--|--|--|
| 1. DECEASED NAME
(TYPE OR PRINT)
FIRST MIDDLE LAST
<i>Samuel FRANKLE</i> | | | 2a. DATE OF DEATH
MONTH DAY YEAR
<i>2 25 82</i> | | | 2b. HOUR
P.M.
<i>8 13</i> | | | | |
| 3. SEX
<i>Male</i> | | 4. RACE
<i>Cauc.</i> | | 5. DATE OF BIRTH
MONTH DAY YEAR
<i>8 26 03</i> | | | 6. AGE (IN YEARS LAST BIRTHDAY)
<i>78</i> YRS. | | | |
| 7. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
<i>MARYLAND</i> | | 7b. CITIZEN OF WHAT COUNTRY?
<i>USA</i> | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
<i>City</i> MD. | | | | |
| 10. CITY OR TOWN OF DEATH
<i>Baltimore</i> | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
<i>Swai Hosp. of Balt.</i> | | | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
<i>SUPERVISOR</i> | | 12b. KIND OF BUSINESS OR INDUSTRY
<i>U.S. POST OFF.</i> | | |
| 13a. STATE
<i>MD</i> | | 13b. COUNTY
<i>BALTO</i> | | 13c. CITY OR TOWN
<i>Balt.</i> | | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS
<i>6994 Millbrook Park Dr.</i> | | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
<i>JOSEPH FRANKLE</i> | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE
<i>CLARA APT 1D 21215 SPECTOR</i> | | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN) <i>NO</i> | | | | | 16b. SOCIAL SECURITY NO.
<i>216 28 1231</i> | |
| 17. INFORMANT <i>MRS. FANNIE FRANKLE</i> | | | | | 17. ADDRESS <i>6994 MILBROOK PARK DR, APT. 1D #21215</i> | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART 1. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <i>Sepsis</i>
<i>5762</i>
DUE TO, OR AS A CONSEQUENCE OF:
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <i>Bile Peritonitis</i>
DUE TO, OR AS A CONSEQUENCE OF:
(c) <i>Common Duct Perforation 2° Peritonitis Transperforative Cholangitis</i> | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:
<i>OBSTRUCTIVE Jaundice</i> | | | | | | | | | | |
| 19a. DATE OF OPERATION
<i>2/23/82</i> | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED
<i>Common Duct Obstruction</i> | | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | | |
| 21d. INJURY OCCURRED
WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from <i>2/2</i> 19 <i>82</i> , to <i>2/25</i> 19 <i>82</i> , that (I) (we) lost
saw the deceased alive on <i>2/25</i> 19 <i>82</i> , and that in my (our) opinion death occurred on the date and hour and from the causes stated
above. (If I (we) did not view the body after death.) | | | | | | | | | | |
| 22b. SIGNATURE
<i>Jeffrey Chirews MD</i> | | | | | | DEGREE | | 22c. DATE SIGNED
<i>2/25/82</i> | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
<i>Jeffrey Chirews MD</i> | | | | | | 22e. ADDRESS
<i>Swai Hospital of Baltimore</i> | | | | |
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY) <i>BURIAL</i> | | | 23b. DATE
<i>FEB. 28, 1982</i> | | 23c. NAME OF CEMETERY OR CREMATORY
<i>MOSES MONTEFIORE WOODMOOR HEBREW</i> | | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
<i>BALTIMORE MD</i> | | |
| 24. FUNERAL DIRECTOR
NAME
<i>SOL LEVINSON & BROS., INC.</i>
ADDRESS
<i>6010 REISTERSTOWN RD. BALTO., MD 21215</i> | | | | | | 25. DATE REC'D. BY REGISTRAR
<i>MAR 4 1982</i> | | 25b. REGISTRAR'S SIGNATURE
<i>Frances Jan. Nathan</i> | | |

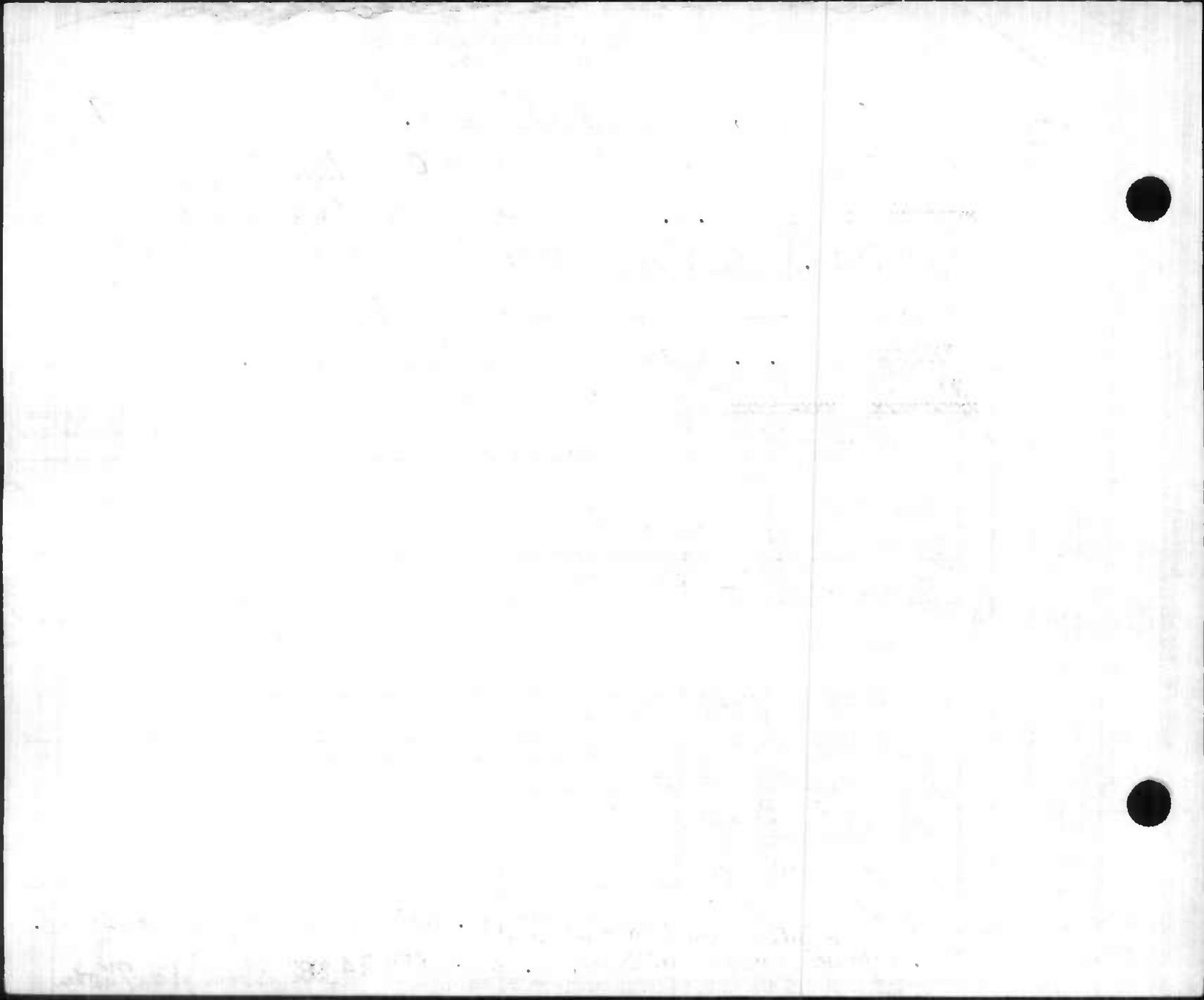


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| STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH | | | | REG. NO. | | | |
|---|--|---|--|---|--|--|--|
| 1. FOR STATE REGISTRAR | | | | 8 2 0 3 1 3 6 | | | |
| 1. DECEASED NAME
(TYPE OR PRINT) <i>Frazier, Kathleen M.</i> | | | | 2a. DATE OF DEATH
MONTH DAY YEAR
<i>02 20 82</i> | | 2b. HOUR
<i>9:20 A.M.</i> | |
| 3. SEX
<i>Female</i> | | 4. RACE
<i>White</i> | | 5. DATE OF BIRTH
MONTH DAY YEAR
<i>8 7 1900</i> | | 6. AGE (IN YEARS LAST BIRTHDAY)
YRS. MONTHS DAYS
<i>81</i> | |
| 7a. BIRTHPLACE
STATE OR FOREIGN COUNTRY
<i>Maryland</i> | | 7b. CITIZEN OF WHAT COUNTRY?
<i>U.S.A.</i> | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input checked="" type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
<i>City, Balto.</i> MD. | |
| 10. CITY OR TOWN OF DEATH
<i>City (Balto.)</i> | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
<i>Lutheran Hospital</i> | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
<i>Retired</i> | | 12b. KIND OF BUSINESS OR INDUSTRY
<i>None</i> | |
| 13a. STATE
<i>Md.</i> | | 13b. COUNTY
<i>City</i> | | 13c. CITY OR TOWN
<i>City</i> | | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
<i>J. H. Frazier</i> | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
<i>Marv E. Stahling</i> | | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(IF YES, GIVE WAR OR DATES)
<i>NO</i> | | 16b. SOCIAL SECURITY NO.
<i>25 01 6002</i> | |
| 17. INFORMANT
<i>Chatt</i> | | 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART 1. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <i>Cardio pulmonary arrest</i>
4275
DUE TO, OR AS A CONSEQUENCE OF
(b) _____
DUE TO, OR AS A CONSEQUENCE OF
(c) _____ | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)
<i>Sepsis Anti renal failure</i> | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | |
| 22a. I certify that (if (this hospital) attended the deceased from <i>01-30</i> , 19 <i>82</i> , to <i>02 10</i> , 19 <i>82</i> , that (he) (we) lost
saw the deceased alive on <i>04/20/82</i> , 19 <i>82</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated
above, (I) (we) (did) (did not) view the body after death. | | | | | | | |
| 22b. SIGNATURE
<i>Elissa Awoka</i> | | | | DEGREE
<i>Elissa Awoka</i> | | 22c. DATE SIGNED
<i>2/20/82</i> | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
<i>Elissa Awoka</i> | | | | 22e. ADDRESS
<i>Lutheran Hospital</i> | | | |
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)
<i>Entombment</i> | | 23b. DATE
<i>2/23/82</i> | | 23c. NAME OF CEMETERY OR CREMATORY
<i>Glen Haven Mem. Park</i> | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
<i>Glen Burnie Anne Arundel Md.</i> | |
| 24. FUNERAL DIRECTOR
NAME ADDRESS
<i>Mc Cully Funeral Home of Brooklyn
237 E. Patapsco Avenue Baltimore, Md. 21225</i> | | | | 25a. DATE REC'D. BY REGISTRAR
<i>FEB 24 1982</i> | | 25b. REGISTRAR'S SIGNATURE
<i>Francis J. W. Warden</i> | |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Burial/cremation fee retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the lines of page 2, should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

FOR
1- STATE
REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | | | |
|---|--|---|--|---|--|--|---|--|--|
| 1. DECEASED NAME
(TYPE OR PRINT)
RE BECCA FRAZIER | | | 2a. DATE OF DEATH
MONTH DAY YEAR
2-10-82 | | | 2b. HOUR
7:00 AM | | | |
| 3. SEX
Female | | 4. RACE
Black | | 5. DATE OF BIRTH
MONTH DAY YEAR
5-18-1898 | | 6. AGE (IN YEARS LAST BIRTHDAY)
84 | | 7. UNDER 1 YEAR
MONTHS DAYS HOURS MIN | |
| 7a. BIRTHPLACE (STATE OF FOREIGN COUNTRY)
North Car. | | 7b. CITIZEN OF WHAT COUNTRY?
USA | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
Baltimore City MD. | | | |
| 10. CITY OR TOWN OF DEATH
Balto. | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
Provident Hospital | | | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE) | | 12b. KIND OF BUSINESS OR INDUSTRY | |
| 13a. STATE
Md. | | | 13b. COUNTY | | 13c. CITY OR TOWN
Balto. | | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
Gussle Barnes | | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
Victoria | | | 16. STREET ADDRESS
4303 Norfolk Ave. | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)
No | | | 16b. SOCIAL SECURITY NO. | | 17. INFORMANT
ADDRESS
Inez Carroll 4303 Norfolk Ave. | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART 1. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>Chronic Renal Failure</u>
4049
DUE TO, OR AS A CONSEQUENCE OF
(b) <u>Congestive Heart Failure</u>
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(c) <u>Hypertension</u> | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: | | | | | | | | | |
| 19a. DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | |
| 21d. INJURY OCCURRED
WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>1/27/82</u> , 19 <u>82</u> , to <u>2/10/82</u> , 19 <u>82</u> , that (I) (we) last saw the deceased alive on <u>2/10/82</u> , 19 <u>82</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | |
| 22b. SIGNATURE
Nigel E.R. Jackman M.D. | | | | | | DEGREE
ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> | | 22c. DATE SIGNED
2/10/82 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
NIGEL E.R. JACKMAN M.D. | | | | | | 22e. ADDRESS
Provident Hospital
2600, Liberty Hgts., Balt. Md | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)
Burial | | | 23b. DATE
2/15/82 | | 23c. NAME OF CEMETERY OR CREMATORY
MT. AUBURN CEMETERY | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
BALTO., MD. | | |
| 24. FUNERAL DIRECTOR
NAME
Leroy O. Dyett 4600 Liberty Hgts. | | | | | | 25a. DATE REC'D. BY REGISTRAR
FEB 16 1982 | | | |



Handwritten text at the bottom left corner, possibly a signature or date.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified on page 3.

4
1 - FOR
STATE
REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 2 0 3 / 3 8

REG. NO.

| | | | | | | | |
|---|--|---|---|---|---------------------------|--|--|
| 1. DECEASED NAME
(TYPE OR PRINT) SAMUEL FREEDMAN | | | 2a. DATE OF DEATH
MONTH 02 DAY 12 YEAR 82 | | 2b. HOUR 4:20 A.M. | | |
| 3. SEX
MALE | | 4. RACE
WHITE | | 5. DATE OF BIRTH
MONTH 01 DAY 25 YEAR 91 | | 6. AGE (IN YEARS LAST BIRTHDAY)
91 YRS | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
MARYLAND | | 7b. CITIZEN OF WHAT COUNTRY?
USA | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
BALTO CITY MD. | |
| 10. CITY OR TOWN OF DEATH
BALTIMORE | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
SINAI Hosp of Balto | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
SALESMAN | | 12b. KIND OF BUSINESS OR INDUSTRY
JEWELRY | |
| 13a. STATE
MD | | 13b. COUNTY
BALTIMORE | | 13c. CITY OR TOWN
BALTIMORE | | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 14. FATHER'S NAME
FIRST BARNETT MIDDLE FREEDMAN LAST ROSE | | 15. MOTHER'S MAIDEN NAME
FIRST ROSE MIDDLE UNKNOWN LAST UNKNOWN | | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
NO | | 16b. SOCIAL SECURITY NO.
3322 CLARKS LA., APT. E | |
| 17. INFORMANT
MRS. SARAH FREEDMAN | | 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART 1. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) MI & pul edema
4100
DUE TO, OR AS A CONSEQUENCE OF (b) ASCVD
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO, OR AS A CONSEQUENCE OF (c) _____ | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | |
| 21d. INJURY OCCURRED
WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 2/7 , 19 82 , to 2/12 , 19 82 that (I) (we) last saw the deceased alive on 2/11 , 19 82 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | |
| 22b. SIGNATURE
Harvey Rosen MD | | | | DEGREE
MD | | 22c. DATE SIGNED
2/12/82 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
Harvey Rosen | | | | 22e. ADDRESS
SINAI Hosp of Balto | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)
BURIAL | | 23b. DATE
FEB. 14, 1982 | | 23c. NAME OF CEMETERY OR CREMATORY
OHEB SHALOM | | 23d. LOCATION
CITY OR TOWN BALTO. STATE MD | |
| 24. FUNERAL DIRECTOR
NAME SOL LEVINSON & BROS., INC.
ADDRESS 6010 REISTERSTOWN RD. BALTO., MD 21215 | | | | 25a. DATE REC'D. BY REGISTRAR
FEB 17 1982 | | 25b. REGISTRAR'S SIGNATURE
Thomas J. [Signature] | |



FEB 15 1965

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 2 0 3 / 3 9

1- FOR
STATE
REGISTRAR

REG. NO.

| | | | | | | | | | | | |
|---|--|---|---|--|----------------------------|---|--|---|--|--|--|
| 1. DECEASED NAME
(TYPE OR PRINT)
FIRST MIDDLE LAST
ROBERT LEE FREY | | | 2a. DATE OF DEATH
MONTH DAY YEAR
2 11 82 | | 2b. HOUR
4 35 PM | | | | | | |
| 3. SEX
MALE | | 4. RACE
WHITE | | 5. DATE OF BIRTH
MONTH DAY YEAR
02 03 13 | | 6. AGE (IN YEARS LAST BIRTHDAY)
69 YRS | | 7. IF UNDER 1 YEAR
MONTHS DAYS
69 | | 8. IF UNDER 24 HRS
HOURS MIN
4 35 | |
| 9. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
MARYLAND | | 10. CITIZEN OF WHAT COUNTRY?
U.S.A. | | 11. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 12. BALTIMORE CITY OR COUNTY OF DEATH
Balt. City MD | | | | | |
| 13. CITY OR TOWN OF DEATH
Balt. City | | 14. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
5664 S. Balto. Gen. Hosp. | | | | 15. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
Sheet metal worker | | | | 16. KIND OF BUSINESS OR INDUSTRY | |
| 17. USUAL RESIDENCE (IF NOT IN SUCH FACILITY, GIVE RESIDENCE BEFORE ADMISSION)
17a. STATE
MARYLAND | | 17b. COUNTY
BALTIMORE | | 17c. CITY OR TOWN
LANSDOWNE | | 17d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 17e. STREET AND NUMBER
238 HAZEL AVENUE, 21227 | | | |
| 18. FATHER'S NAME
FIRST MIDDLE LAST
WILLIAM FREY | | 19. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
MARY McMANN | | | | | | | | | |
| 20. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
NO | | 21. SOCIAL SECURITY NO.
216-01-6369 | | 22. INFORMANT ADDRESS
MARGARET G. FREY 238 HAZEL AVENUE, 21227 | | | | | | | |
| 23. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) CVA
4360
Conditions, if any, which gave rise to immediate cause (b) stating the underlying cause last
HBP
DUE TO, OR AS A CONSEQUENCE OF
DUE TO, OR AS A CONSEQUENCE OF
(c)
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| 24. DATE OF OPERATION | | 25. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 26. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 27. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | | |
| 28. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 29. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 30. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | | | | | |
| 31. INJURY OCCURRED
WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 32. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 33. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | | | | | |
| 34. I certify that (I) (this hospital) attended the deceased from 2/7 19 82 to 2/11 19 82 that (I) (we) lost
saw the deceased alive on 2/11 19 82 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated
above (I) (we) (did) (did not) view the body after death. | | | | | | | | | | | |
| 35. SIGNATURE
G. Hallick | | 36. DEGREE
MD | | 37. ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> | | | | 38. DATE SIGNED
2/11/82 | | | |
| 39. PHYSICIAN'S NAME (TYPE OR PRINT)
HALLICK | | 40. ADDRESS
3001 S. Hanover St. | | | | | | | | | |
| 41. BURIAL, CREMATION, REMOVAL
(SPECIFY)
BURIAL | | 42. DATE
02-15-82 | | 43. NAME OF CEMETERY OR CREMATORY
MEADOWRIDGE MEM. PK. | | | | 44. LOCATION
CITY OR TOWN COUNTY STATE
ELKRIDGE HOWARD MARYLAND | | | |
| 45. FUNERAL DIRECTOR
NAME
HUBBARD FUNERAL HOME, INC. | | 46. ADDRESS
4107 WILKENS AVE. | | 47. DATE REC'D. BY REGISTRAR
FEB 16 1982 | | 48. REGISTRAR'S SIGNATURE
Bruce J. Smith | | | | | |

MEDICAL CERTIFICATION

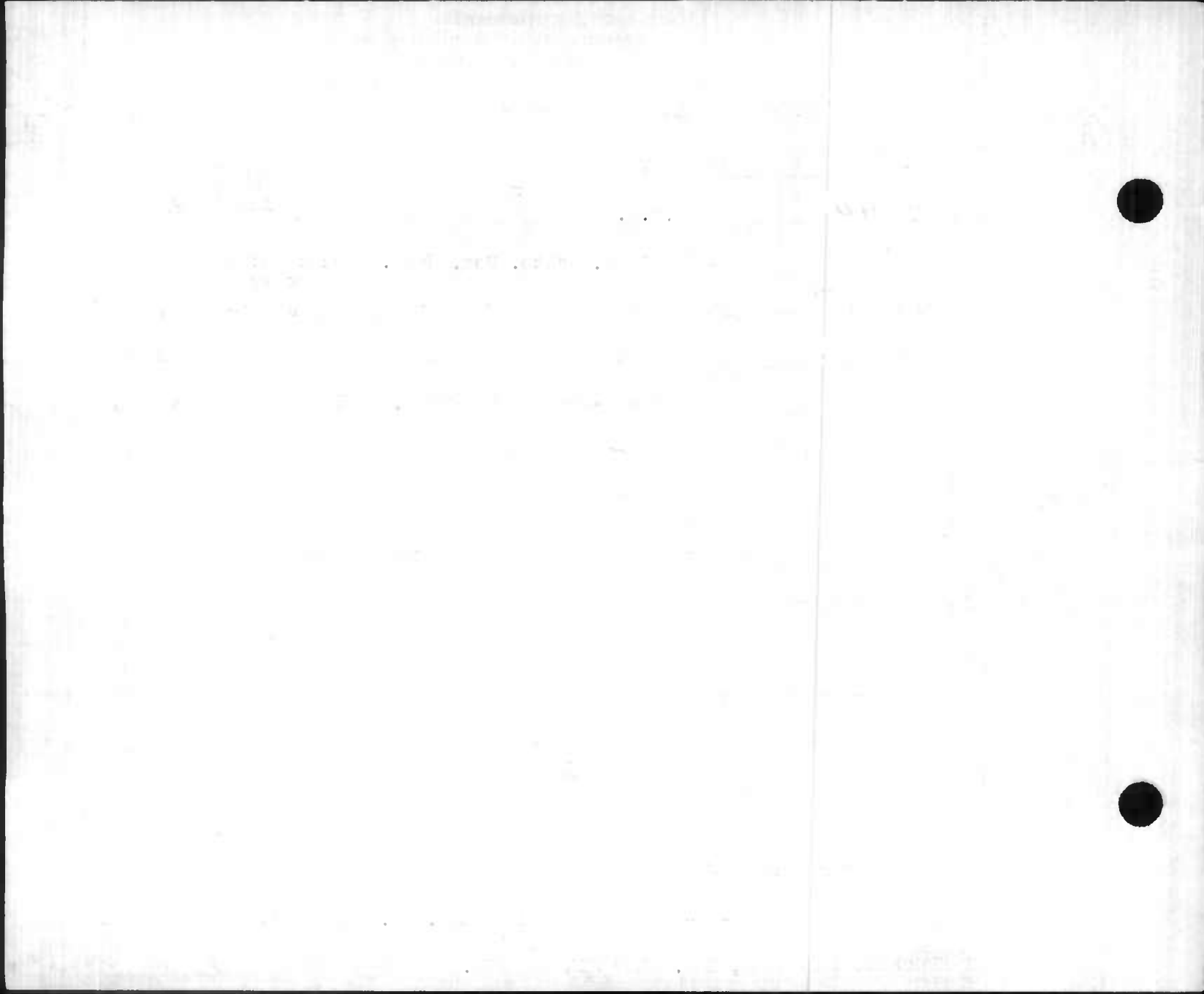
2
9

1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. For this purpose, the law requires that the death certificate be executed within 24 hours after death. For this purpose, the law requires that the death certificate be executed within 24 hours after death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.



TO HOSPITAL OR ATTENDING PHYSICIAN. The low requires to be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death. Page 3 should be filed within 72 hours after death. Page 4 should be filed within 72 hours after death. Page 5 should be filed within 72 hours after death. Page 6 should be filed within 72 hours after death. Page 7 should be filed within 72 hours after death. Page 8 should be filed within 72 hours after death. Page 9 should be filed within 72 hours after death. Page 10 should be filed within 72 hours after death. Page 11 should be filed within 72 hours after death. Page 12 should be filed within 72 hours after death. Page 13 should be filed within 72 hours after death. Page 14 should be filed within 72 hours after death. Page 15 should be filed within 72 hours after death. Page 16 should be filed within 72 hours after death. Page 17 should be filed within 72 hours after death. Page 18 should be filed within 72 hours after death. Page 19 should be filed within 72 hours after death. Page 20 should be filed within 72 hours after death. Page 21 should be filed within 72 hours after death. Page 22 should be filed within 72 hours after death. Page 23 should be filed within 72 hours after death. Page 24 should be filed within 72 hours after death. Page 25 should be filed within 72 hours after death. Page 26 should be filed within 72 hours after death. Page 27 should be filed within 72 hours after death. Page 28 should be filed within 72 hours after death. Page 29 should be filed within 72 hours after death. Page 30 should be filed within 72 hours after death. Page 31 should be filed within 72 hours after death. Page 32 should be filed within 72 hours after death. Page 33 should be filed within 72 hours after death. Page 34 should be filed within 72 hours after death. Page 35 should be filed within 72 hours after death. Page 36 should be filed within 72 hours after death. Page 37 should be filed within 72 hours after death. Page 38 should be filed within 72 hours after death. Page 39 should be filed within 72 hours after death. Page 40 should be filed within 72 hours after death. Page 41 should be filed within 72 hours after death. Page 42 should be filed within 72 hours after death. Page 43 should be filed within 72 hours after death. Page 44 should be filed within 72 hours after death. Page 45 should be filed within 72 hours after death. Page 46 should be filed within 72 hours after death. Page 47 should be filed within 72 hours after death. Page 48 should be filed within 72 hours after death. Page 49 should be filed within 72 hours after death. Page 50 should be filed within 72 hours after death. Page 51 should be filed within 72 hours after death. Page 52 should be filed within 72 hours after death. Page 53 should be filed within 72 hours after death. Page 54 should be filed within 72 hours after death. Page 55 should be filed within 72 hours after death. Page 56 should be filed within 72 hours after death. Page 57 should be filed within 72 hours after death. Page 58 should be filed within 72 hours after death. Page 59 should be filed within 72 hours after death. Page 60 should be filed within 72 hours after death. Page 61 should be filed within 72 hours after death. Page 62 should be filed within 72 hours after death. Page 63 should be filed within 72 hours after death. Page 64 should be filed within 72 hours after death. Page 65 should be filed within 72 hours after death. Page 66 should be filed within 72 hours after death. Page 67 should be filed within 72 hours after death. Page 68 should be filed within 72 hours after death. Page 69 should be filed within 72 hours after death. Page 70 should be filed within 72 hours after death. Page 71 should be filed within 72 hours after death. Page 72 should be filed within 72 hours after death. Page 73 should be filed within 72 hours after death. Page 74 should be filed within 72 hours after death. Page 75 should be filed within 72 hours after death. Page 76 should be filed within 72 hours after death. Page 77 should be filed within 72 hours after death. Page 78 should be filed within 72 hours after death. Page 79 should be filed within 72 hours after death. Page 80 should be filed within 72 hours after death. Page 81 should be filed within 72 hours after death. Page 82 should be filed within 72 hours after death. Page 83 should be filed within 72 hours after death. Page 84 should be filed within 72 hours after death. Page 85 should be filed within 72 hours after death. Page 86 should be filed within 72 hours after death. Page 87 should be filed within 72 hours after death. Page 88 should be filed within 72 hours after death. Page 89 should be filed within 72 hours after death. Page 90 should be filed within 72 hours after death. Page 91 should be filed within 72 hours after death. Page 92 should be filed within 72 hours after death. Page 93 should be filed within 72 hours after death. Page 94 should be filed within 72 hours after death. Page 95 should be filed within 72 hours after death. Page 96 should be filed within 72 hours after death. Page 97 should be filed within 72 hours after death. Page 98 should be filed within 72 hours after death. Page 99 should be filed within 72 hours after death. Page 100 should be filed within 72 hours after death.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH | | | | | | | | | | 8 2 0 3 7 4 0 | |
|--|--|--|--|---|--|--|--|--|--|--|--|
| 1. FOR STATE REGISTRAR | | | | | | | | | | REG. NO. | |
| 1. DECEASED NAME (TYPE OR PRINT)
FIRST MIDDLE LAST
THERESA AGNES FRITZ | | | | | | 2a. DATE OF DEATH
MONTH DAY YEAR
FEBRUARY 16 1982 | | 2b. HOUR
8:30 A | | | |
| 3. SEX
Female | | 4. RACE
White | | 5. DATE OF BIRTH
MONTH DAY YEAR
8 20 1925 | | 6. AGE (IN YEARS LAST BIRTHDAY)
56 | | IF UNDER 1 YEAR
MONTHS DAYS HOURS MIN.
YRS | | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
Maryland | | 7b. CITIZEN OF WHAT COUNTRY?
U.S.A. | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
BALTIMORE CITY MD. | | | | | |
| 10. CITY OR TOWN OF DEATH
Baltimore | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
JOHNS HOPKINS HOSPITAL | | | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
Housewife | | 12b. KIND OF BUSINESS OR INDUSTRY | | | |
| 13a. STATE
Maryland | | 13b. COUNTY
Baltimore | | 13c. CITY OR TOWN
Dundalk | | 13d. INSIDE CITY LIMITS?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 13e. STREET ADDRESS
7614 Gum Road | | | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
James H. Carroll, Sr. | | | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
Elizabeth Agnes Rausinger | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
No | | 16b. SOCIAL SECURITY NO.
219-14-0299 | | 17. INFORMANT
Ralph L. Fritz, Sr. | | | | ADDRESS
7614 Gum Road Balto. MD 21222 | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART 1. DEATH WAS CAUSED BY:
1749 IMMEDIATE CAUSE (a) HYPERCALCEMIA
DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b) METASTATIC BREAST CARCINOMA.
DUE TO, OR AS A CONSEQUENCE OF
(c) _____ | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
1 DAY
6 YEARS | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | | | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/> | | | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 15 FEB 19 82 to 16 FEB 19 82 , that (I) (we) lost
saw the deceased alive on 16 FEB 19 82 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated
above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | | | |
| 22b. SIGNATURE
[Signature] | | | | | | DEGREE
ATTENDING PHYSICIAN MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> | | 22c. DATE SIGNED
2/16/82 | | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
ANASTACIO R. DE CASTRO | | | | | | 22e. ADDRESS
JOHNS HOPKINS HOSPITAL | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)
Burial | | | | 23b. DATE
2/19/82 | | 23c. NAME OF CEMETERY OR CREMATORY
Gardens of Faith | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
Baltimore Maryland | | | |
| 24. FUNERAL DIRECTOR
NAME
Duda-Ruck, Inc. | | | | | | ADDRESS
7922 Wise Avenue, Dundalk, MD 21222 | | 25a. DATE REC'D. BY REGISTRAR
FEB 22 1982 | | | |
| | | | | | | 25b. REGISTRAR'S SIGNATURE
[Signature] | | | | | |

2 0 3 7 4 1

REG. NO.

MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, THE MEDICAL EXAMINER SHOULD EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 1B. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL HOME OR TO THE FUNERAL DIRECTOR. GIVE PAGE 4 TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM-3. RETAIN PAGE 5 FOR YOUR FILES.

TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN YOUR GROUP, AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

DHMH - 17
(VR A15 ME (5))
15M 2/80



5011 00 11 037

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours of death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH | | | | 8 2 0 3 / 4 2 | | | |
|--|--|--|--|---|--|--|--|
| 1. FOR STATE REGISTRAR | | | | REG. NO. | | | |
| 1. DECEASED NAME
(TYPE OR PRINT) Leonard N. Fullwood | | | | 2a. DATE OF DEATH
MONTH DAY YEAR
2/17/82 | | 2b. HOUR
10⁵² P M | |
| 3. SEX
M | | 4. RACE
B | | 5. DATE OF BIRTH
MONTH DAY YEAR
5 8 19 | | 6. AGE (IN YEARS LAST BIRTHDAY)
62 YRS. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
S.C. | | 7b. CITIZEN OF WHAT COUNTRY?
USA | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
Baltimore city MD. | |
| 10. CITY OR TOWN OF DEATH
Baltimore | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
Luthern Hospital | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE) | | 12b. KIND OF BUSINESS OR INDUSTRY | |
| 13a. STATE
Md | | 13b. COUNTY
Baltimore | | 13c. INSIDE CITY LIMITS?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | 13d. STREET ADDRESS
2503 W. Lafayette Avenue | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
Luther Fullwood | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
Ella | | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)
No | | | |
| 16b. SOCIAL SECURITY NO.
216-12-4274 | | 17. INFORMANT ADDRESS
Golden Fullwood 2503 W. Lafayette | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART 1. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Cardiac arrest
7070
DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b) E. coli Sepsis
DUE TO, OR AS A CONSEQUENCE OF
(c) Decubitus ulcer
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)
Diabetes Mellitus | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 2/17 82 to 2/17 1982 , that (I) (we) lost
saw the deceased alive on 2/17 1982 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated
above, (I) (we) (did) (did not) view the body after death. | | | | | | | |
| 22b. SIGNATURE
Moses Gebremariam | | | | DEGREE
MD | | 22c. DATE SIGNED
2/17/82 | |
| 23a. PHYSICIAN'S NAME (TYPE OR PRINT)
Moses Gebremariam | | | | 23b. ADDRESS | | | |
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY) Burial | | 23b. DATE
2/22/82 | | 23c. NAME OF CEMETERY OR CREMATORY
Cedar Hill Cem | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
Anne Arundel Co Md | |
| 24. FUNERAL DIRECTOR
NAME
William C. March F/H 1101 | | | | ADDRESS
E. North Ave | | 25a. DATE REC'D. BY REGISTRAR
FEB 19 1982 | |
| | | | | 25b. REGISTRAR'S SIGNATURE
Thomas J. Martin | | | |

1-10-83

2-10-83

3-10-83

4-10-83

5-10-83

6-10-83

7-10-83

8-10-83

9-10-83

10-10-83

11-10-83

12-10-83

1-11-83

2-11-83

3-11-83

John P. ...

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 must be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH | | | | | | | | | | REG. NO. 8 2 0 3 7 4 3 | |
|--|--|---|--|---|--|--|--|--|--|------------------------|--|
| 1. DECEASED NAME
(TYPE OR PRINT) GEORGE A GAFOS | | | | | | 2a. DATE OF DEATH
MONTH DAY YEAR
2 21 82 | | 2b. HOUR
4:50 AM | | | |
| 3. SEX
MALE | | 4. RACE
White | | 5. DATE OF BIRTH
MONTH DAY YEAR
2 11 04 | | 6. AGE (IN YEARS LAST BIRTHDAY)
78 yr. | | IF UNDER 1 YEAR
MONTHS DAYS HOURS MIN.
YRS. | | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
GREECE | | 7b. CITIZEN OF WHAT COUNTRY?
U.S.A. | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
BALTIMORE CITY MD | | | | | |
| 10. CITY OR TOWN OF DEATH
BALTIMORE | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
UNIVERSITY OF MARYLAND HEP. | | | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
RETIRED | | 12b. KIND OF BUSINESS OR INDUSTRY
Ship Captain | | | |
| 13a. STATE
MARYLAND | | 13b. COUNTY
- | | 13c. CITY OR TOWN
BALTIMORE | | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS
Balt., Md. 21213
3311 SHANNON DRIVE, MD 21213 | | | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
ADAMANDIOS Y GAFOS | | | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
Anthevy - Skoufalou | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES NO OR UNKNOWN)
No | | | | 16b. SOCIAL SECURITY NO.
109-18-5585 | | 17. INFORMANT
Son: Adam G. Gafos ADDRESS Balt., Md. 21213
3303 Romona Avenue | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART 1. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) CARDIO-PULMONARY ARREST
4860
DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last:
(b) PNEUMONIA
DUE TO, OR AS A CONSEQUENCE OF
(c) _____
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (d)
POORLY DIFFERENTIATED DIFFUSE LYMPHOCYTIC LYMPHOMA | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | | | | | | | | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | | | |
| 21d. INJURY OCCURRED
WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | | | 21e. PLACE OF INJURY
(AT HOME STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from FEB. 9 19 82 , to FEB 21 19 82 , that (I) (we) lost
saw the deceased alive on FEB 21 19 82 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated
above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | | | |
| 22b. SIGNATURE
N. LWIN | | | | | | DEGREE
ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> | | 22c. DATE SIGNED
2/21/82 | | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
N. LWIN | | | | | | 22e. ADDRESS | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY) Burial | | 23b. DATE
Feb 24 1982 | | 23c. NAME OF CEMETERY OR CREMATORY
Greek Orthodox | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
Baltimore Maryland | | | | | |
| 24. FUNERAL DIRECTOR
NAME
Leonard J. Ruck, Inc. ADDRESS
Baltimore Maryland | | | | | | 25a. DATE REC'D. BY REGISTRAR FEB 22 1982 25b. REGISTRAR'S SIGNATURE
Frances Jan Nathan | | | | | |

20 to

2633 BP

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

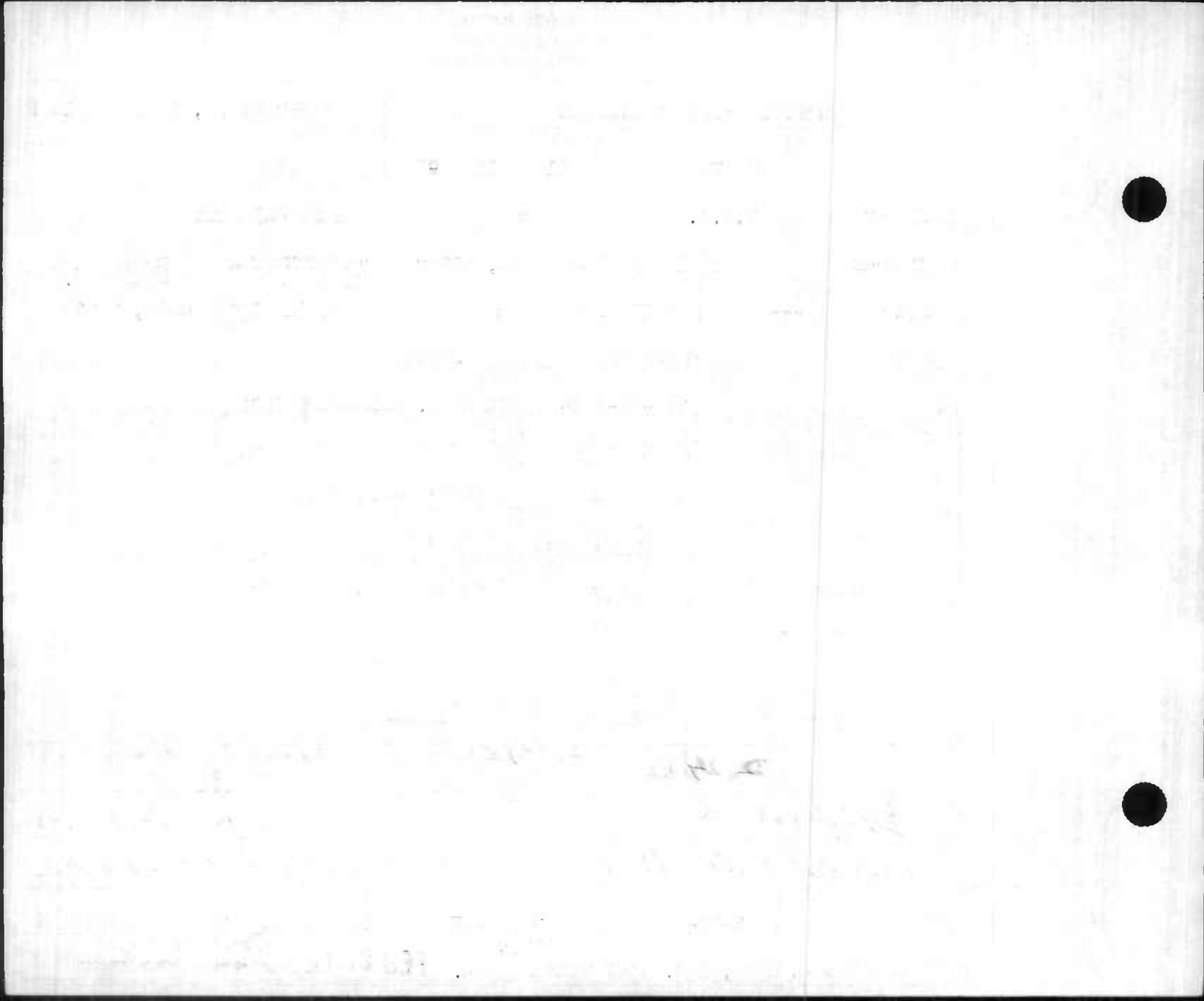
IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified immediately.

1 - FOR
STATE
REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | |
|---|--|---|--|--|--|
| 1. DECEASED NAME
(TYPE OR PRINT)
WALTER GEORGE GALLAGHER | | | 2a. DATE OF DEATH
MONTH DAY YEAR
FEBRUARY 24, 1982 | | 2b. HOUR
1:18 P.M. |
| 3. SEX
MALE | 4. RACE
WHITE | 5. DATE OF BIRTH
MONTH DAY YEAR
11 13 07 | | 6. AGE (IN YEARS LAST BIRTHDAY)
74 YRS. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
MARYLAND | 7b. CITIZEN OF WHAT COUNTRY?
U.S.A. | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
BALTIMORE CITY MD. | |
| 10. CITY OR TOWN OF DEATH
BALTIMORE | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
3591 BENZINGER ROAD, 21229 | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
REFRIGERATOR MECHANIC | | 12b. KIND OF BUSINESS OR INDUSTRY
BORDEN ICE CREAM CO. |
| 13a. STATE
MARYLAND | 13b. COUNTY
--- | 13c. CITY OR TOWN
BALTIMORE | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
JOHN GALLAGHER | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
JULIE LESZEKI | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
NO | | 16b. SOCIAL SECURITY NO.
215-03-2818 | | 17. INFORMANT
ADDRESS
DONALD F. GALLAGHER 3591 BENZINGER ROAD | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART 1. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Vascular Gangrene Small bowel
4100
DUE TO, OR AS A CONSEQUENCE OF
(b) ASCD & atrial fibrillation
DUE TO, OR AS A CONSEQUENCE OF
(c) ASCD, M.I.
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)
old age, gout, COPD, senile dementia. | | | | | |
| 19a. DATE OF OPERATION
2/14/82 2/19/82 | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED
S.M.A. occlusion. | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | |
| 21d. INJURY OCCURRED
WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | |
| 22a. I certify that (I) (this hospital) attended the deceased from 2/13/82 , 19 82 , to 2/24/82 , 19 82 , that (I) (we) last saw the deceased alive on 2/24/82 , 19 82 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | |
| 22b. SIGNATURE
Nanavali | | DEGREE | | 22c. DATE SIGNED
2/24/82 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
Nanavali A.L. | | 22e. ADDRESS
St Agnes Hospital | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)
BURIAL | | 23b. DATE
02-27-82 | | 23c. NAME OF CEMETERY OR CREMATORY
LOUDON PARK | |
| 23d. LOCATION
CITY OR TOWN COUNTY STATE
BALTIMORE CITY MARYLAND | | | | | |
| 24. FUNERAL DIRECTOR
NAME
HUBBARD FUNERAL HOME, INC. | | ADDRESS
4107 WILKENS AVE. | | 25a. DATE REC'D. BY REGISTRAR
FEB 26 1982 | |
| | | 25b. REGISTRAR'S SIGNATURE
<i>Shaw</i> | | | |



TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, THE EXAMINER SHOULD WRITE "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL HOME. EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL HOME. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITH THE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

1- FOR
STATE
REGISTRAR

1. DECEASED NAME
(TYPE OR PRINT)

FIRST

MIDDLE

LAST

A NITA

GALLOWAY

2a. DATE KNOWN
OF
DEATHESTI-
MATED

MONTH

DAY

YEAR

2

7

19

82

2b. HOUR

M

3. SEX

female

4. RACE

black

5. DATE OF BIRTH

MONTH

DAY

YEAR

7

25

64

6. AGE (IN YEARS
(LAST BIRTHDAY)

17

YRS.

IF UNDER 1 YR.

MONTHS

DAYS

HOURS

MIN.

IF UNDER 24 HRS.

7c. DATE
PRONOUNCED
DEAD

MONTH

DAY

YEAR

2

7

19

82

2d. HOUR

M

9:51

7. BIRTHPLACE (STATE OR
FOREIGN COUNTRY)

LOUISIANA

7b. CITIZEN OF WHAT COUNTRY?

USA

8. MARRIED ☐ NEVER MARRIED ☒WIDOWED ☐ DIVORCED ☐

9. BALTIMORE CITY OR COUNTY OF DEATH

Baltimore City

MD

10. CITY OR TOWN OF DEATH

Baltimore

11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION

1427 N. Gay Street

12a. USUAL OCCUPATION (TYPE OF WORK
FOR MOST OF WORKING LIFE)

Student

12b. KIND OF BUSINESS
OR INDUSTRY

USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

13a. STATE

Md.

13b. COUNTY

Baltimore

13c. CITY OR TOWN

Baltimore

13d. INSIDE CITY LIMITS?

YES ☒ NO ☐

13e. STREET ADDRESS

2328 Norfolk Street

14. FATHER'S NAME

FIRST

John E.

MIDDLE

Uebis

LAST

15. MOTHER'S MAIDEN NAME

FIRST

Pearline

MIDDLE

Harris

LAST

16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO, OR UNKNOWN)

16b. SOCIAL SECURITY NO.

17. INFORMANT

ADDRESS

Pearline Harris 2328 Norfolk St.

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a)

Craneo-cerebral trauma

9689

Conditions, if any, which
gave rise to immediate
cause (a) stating the under-
lying cause lost.

DUE TO, OR AS A CONSEQUENCE OF

(b)

DUE TO, OR AS A CONSEQUENCE OF

(c)

APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATH

PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1

19a. DATE OF OPERATION

19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?

20. AUTOPSY?

YES ☒NO ☐

21a. EXTERNAL CAUSE WAS

UNDERLYING ☐ ORCONTRIBUTING ☐ CAUSE OF DEATH

21b. TIME OF INJURY

HOUR A.M.

MONTH

DAY

YEAR

9:50AM

2/7

19

82

21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1b PART 1 OR PART 2)

blunt force injury to head

21d. INJURY OCCURRED

WHILE ☐ NOT WHILE ☒AT WORK ☐ AT WORK ☒

21e. PLACE OF INJURY (AT HOME,

STREET, FACTORY, FARM, ETC.)

clubroom

21f. LOCATION

STREET

1427NGayStreet, Baltimore,

COUNTY

MD

STATE

22a. I certify that I took charge of the remains described above, held on

Autopsy ☒Inspection ☐Inquiry ☐

and in my opinion

death resulted from:

Natural causes ☐Accident ☐Suicide ☐Homicide ☒Undetermined manner ☐ACTUAL
SIGNATURE

Thomas D. Smith

M.D.

TITLE (SPECIFY)

Deputy Chief

MEDICAL EXAMINER

DATE
SIGNED

2/8/82

EXAMINER'S NAME
(TYPE OR PRINT)

Thomas D. Smith, M.D.

ADDRESS

111 Penn Street, Balto. MD 21201

23a. BURIAL, CREMATION, REMOVAL

BURIAL

23b. DATE

2/13/82

23c. NAME OF CEMETERY OR CREMATORY

Mt. Auburn

23d. LOCATION

Baltimore Co.

COUNTY

md.

STATE

24. FUNERAL DIRECTOR

NAME

Nancy M. Wallace

ADDRESS

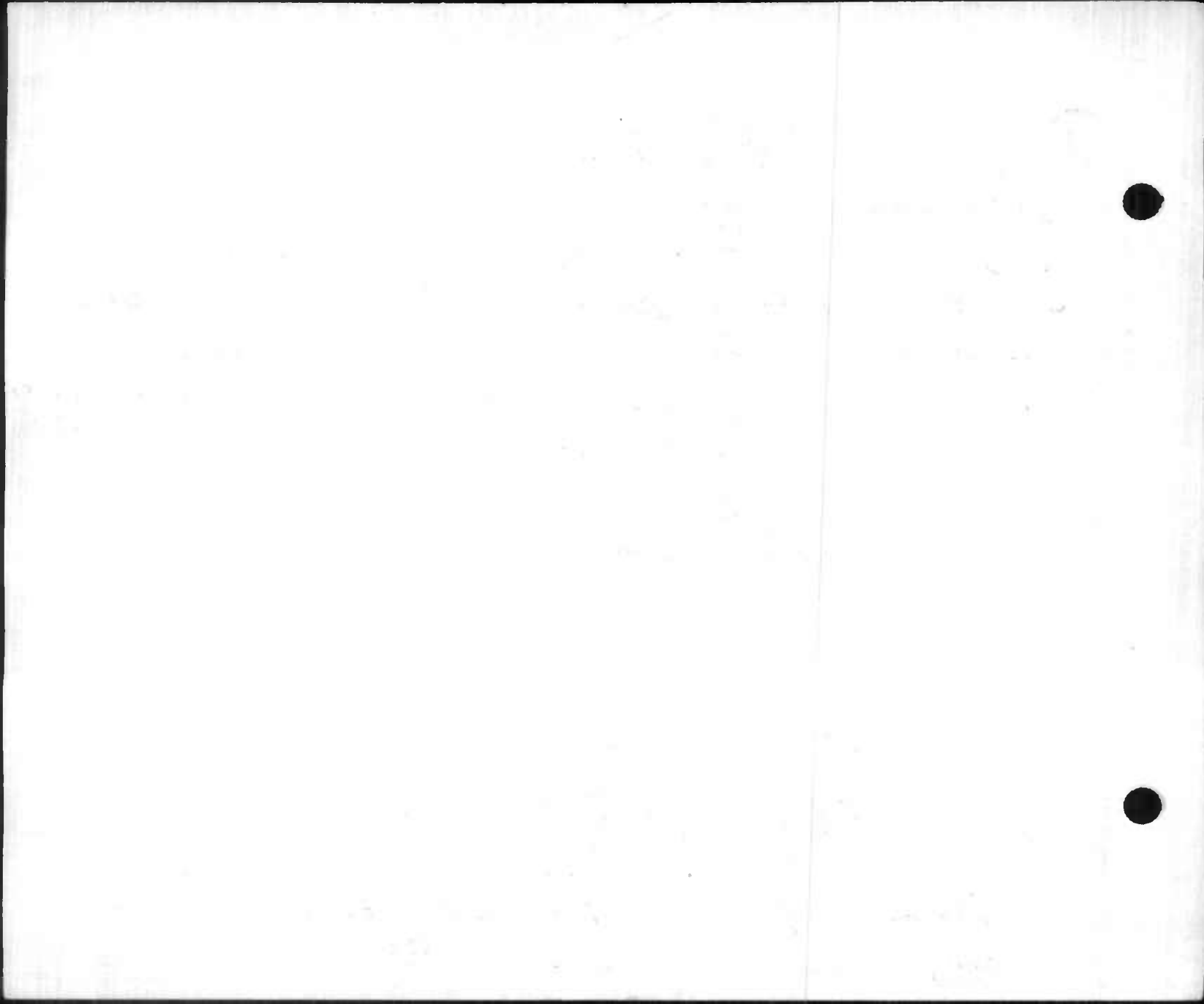
3405 W. Franklin St

25a. DATE REC'D. BY REGISTRAR

FEB 16 1982

25b. REGISTRAR'S SIGNATURE

Thomas D. Smith



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed in the office of the Health Officer after death has been reported. Pages 3 and 4 should be retained by the funeral director. The certificate must be retained by the State Dept of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be

1 - FOR
STATE
REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | | | | | | | | | | | | | |
|--|--|--|--|---|--|---|--|---|--|---|--|-----------------|--|------|--|--|--|----------------------------|--|
| DECEASED NAME
(TYPE OR PRINT) | | FIRST | | MIDDLE | | LAST | | 2a DATE OF DEATH | | MONTH | | DAY | | YEAR | | 2b HOUR | | | |
| Herman | | | | | | Gamble | | 2 20 82 | | 24 | | A.M. | | | | | | | |
| 3 SEX | | 4 RACE | | 5. DATE OF BIRTH | | | | 6 AGE (IN YEARS LAST BIRTHDAY) | | | | IF UNDER 1 YEAR | | | | IF UNDER 24 HRS | | | |
| Male | | Black | | MONTH 3 DAY 1 YEAR 10 | | | | 71 | | | | MONTHS | | | | DAYS | | | |
| 7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) | | 7b CITIZEN OF WHAT COUNTRY? | | 8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | | | 9 BALTIMORE CITY OR COUNTY OF DEATH | | | | | | | | | | | |
| Barro, MD | | USA | | | | | | Baltimore City MD. | | | | | | | | | | | |
| 10 CITY OR TOWN OF DEATH | | 11. NAME OF HOSPITAL (IF NURSING HOME OR OTHER INSTITUTION, GIVE STREET ADDRESS) | | 12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | | | | 12b KIND OF BUSINESS OR INDUSTRY | | | | | | | | | | | |
| Baltimore | | Baltimore Hospital for Deaf and Blind | | Retired | | | | House | | | | | | | | | | | |
| 13a STATE | | 13b COUNTY | | 13d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | | 13e STREET ADDRESS | | | | | | | | | | | |
| MD | | Baltimore | | | | | | 1820 Spruce St | | | | | | | | | | | |
| 14 FATHER'S NAME | | 15 MOTHER'S MAIDEN NAME | | | | | | | | | | | | | | | | | |
| Charles Gamble | | Eva Cornish | | | | | | | | | | | | | | | | | |
| 16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) | | 16b SOCIAL SECURITY NO. | | 17 INFORMANT | | | | ADDRESS | | | | | | | | | | | |
| No | | 212-01-4601 | | Dorlene Gamble | | | | 1820 Spruce St | | | | | | | | | | | |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: | | | | | | | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | | |
| IMMEDIATE CAUSE (a) Cardio-pulmonary Arrest | | | | | | | | | | | | | | | | Minutes | | | |
| 7070 DUE TO, OR AS A CONSEQUENCE OF (b) Sepsis, probable. | | | | | | | | | | | | | | | | ~ 2 days. | | | |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (c) Decubitus infection. | | | | | | | | | | | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1. Multiple C.O.D.s, large sacral decubitus, neurogenic bladder, A&V | | | | | | | | | | | | | | | | | | | |
| 19a DATE OF OPERATION | | 19b CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | | | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | | | | | | | | | |
| | | | | | | | | | | | | | | | | | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | | | 21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | | | | | | | | | | | |
| | | | | | | | | | | | | | | | | | | | |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | | | | | | | | | | | |
| | | | | | | | | | | | | | | | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 7/24 19 82 to 2/20 19 82, that (I) (we) last saw the deceased alive on 2/20 19 82, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death. | | | | | | | | | | | | | | | | | | | |
| 22b. SIGNATURE | | | | | | | | | | | | | | | | DEGREE | | 22c. DATE SIGNED | |
| Dorlene Gamble | | | | | | | | | | | | | | | | | | 2/20/82 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) | | | | | | | | | | | | | | | | 22e. ADDRESS | | | |
| Dorlene Gamble | | | | | | | | | | | | | | | | Baltimore City Hospitals | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) | | 23b. DATE | | 23c. NAME OF CEMETERY OR CREMATORY | | | | 23d. LOCATION CITY OR TOWN COUNTY STATE | | | | | | | | | | | |
| Burial | | 2/24/82 | | Mt. Airy Cemetery | | | | Baltimore MD | | | | | | | | | | | |
| 24. FUNERAL DIRECTOR NAME | | | | | | | | | | | | | | | | 24b. DATE REC'D. BY REGISTRAR | | 25b. REGISTRAR'S SIGNATURE | |
| Man Sank R. Johnson | | | | | | | | | | | | | | | | FEB 22 1982 | | [Signature] | |

DHMH - 16 60M 1/75
(VR A 15 (4))

1958-1959

TO HOSPITAL AND ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

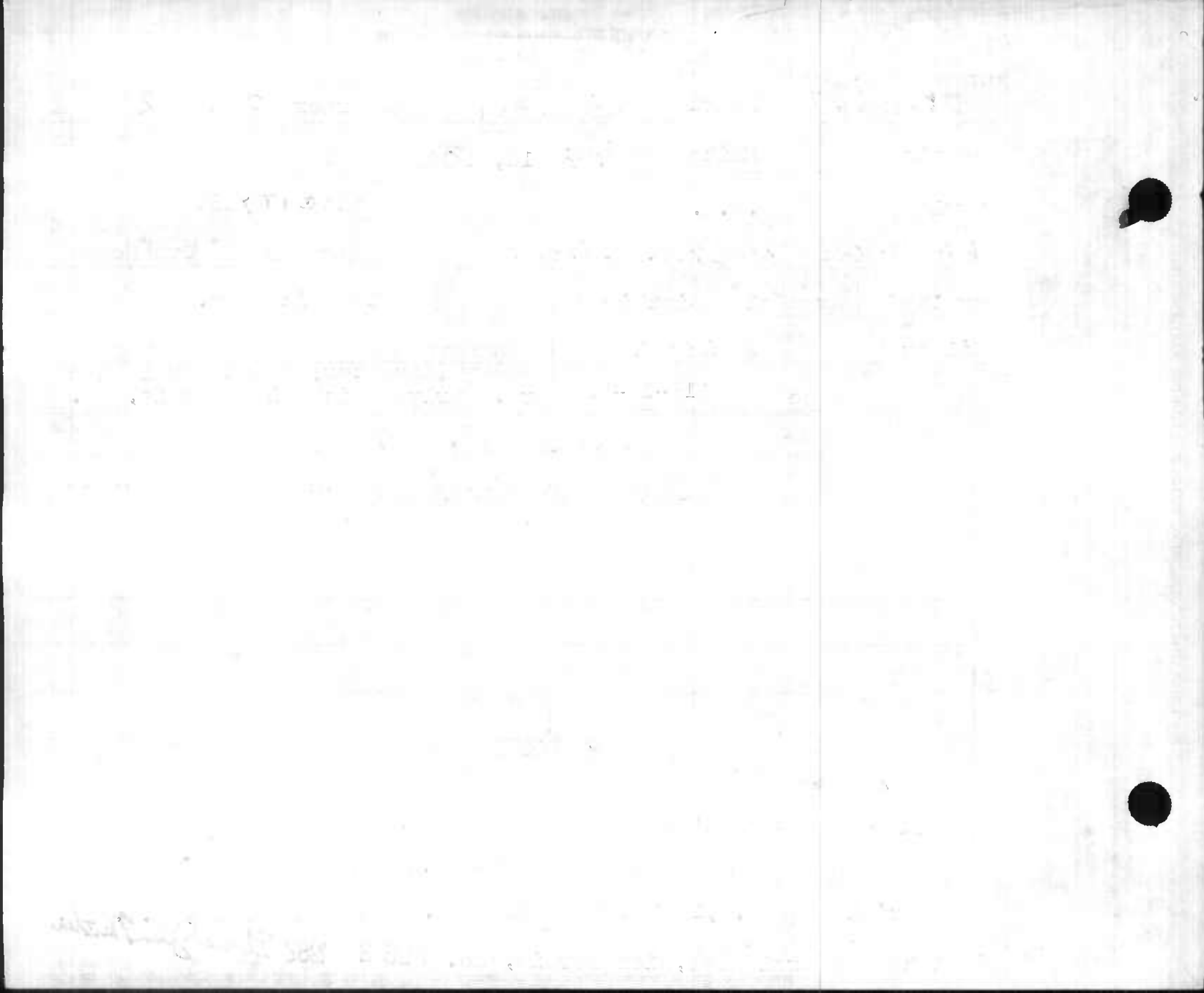
IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

82 03 / 47

| | | | | | |
|---|--|---|--|---|--|
| 1. STATE REGISTRAR | | FOR | | REG. NO. | |
| 1 DECEASED NAME (TYPE OR PRINT) Mabel Pearl | | MIDDLE Garey | | 2a. DATE OF DEATH MONTH DAY YEAR February 1 82 | |
| 3 SEX Female | | 4 RACE White | | 5 DATE OF BIRTH MONTH DAY YEAR June 11, 1902 | |
| 6 AGE (IN YEARS LAST BIRTHDAY) 79 YRS. | | 7b. CITIZEN OF WHAT COUNTRY? U.S.A. | | 8. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City MD | |
| 9a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland | | 9b. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 10. CITY OR TOWN OF DEATH BALTIMORE | |
| 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) MFL Nursing Home | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Homemaker | | 12b. KIND OF BUSINESS OR INDUSTRY Own Home | |
| 13a. STATE Maryland | | 13b. COUNTY Anne | | 13c. CITY OR TOWN Linthicum | |
| 14 FATHER'S NAME FIRST MIDDLE LAST Wilber Michael | | 15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Unknown | | 16. STREET ADDRESS 816 White Ave. | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No | | 16b. SOCIAL SECURITY NO. 216-10-7508 | | 17 INFORMANT (Daughter) ADDRESS Cathedral Place Mrs. Marlyn Smith Glen Burnie, Md. | |
| 18 CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY
IMMEDIATE CAUSE (a) Cardiorespiratory Arrest
4149
DUE TO, OR AS A CONSEQUENCE OF
(b) Ischemic Heart Disease, Afib
DUE TO, OR AS A CONSEQUENCE OF
(c)
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH years. | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR 9 19 81 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) | |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | |
| 22a. I certify that (I) (this hospital) attended the deceased from 9 Feb 81 to 1 Feb 82 , that (I) (we) lost saw the deceased alive on 1 Feb 82 19 82 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | |
| 22b. SIGNATURE Edmunds Beacham MD | | DEGREE MD | | 22c. DATE SIGNED 1 Feb 82 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) E.G. BEACHAM MD | | 22e. ADDRESS BALTIMORE CITY Hosps. | | 22f. ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | | 23b. DATE Feb. 4, 1982 | | 23c. NAME OF CEMETERY OR CREMATORY Cedar Hill Cem. | |
| 23d. LOCATION CITY OR TOWN Brooklyn Park | | COUNTY A. | | STATE MD | |
| 24 FUNERAL DIRECTOR NAME R. B. Hopkins | | ADDRESS Singleton Funeral Home, Glen Burnie, Md. | | 25. DATE REC'D. BY REGISTRAR FEB 2 1982 | |

BP



RELEASED NON-MED PER DR KORELL/MR. FREEMAN

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 of 4 retained by the hospital or attending physician.

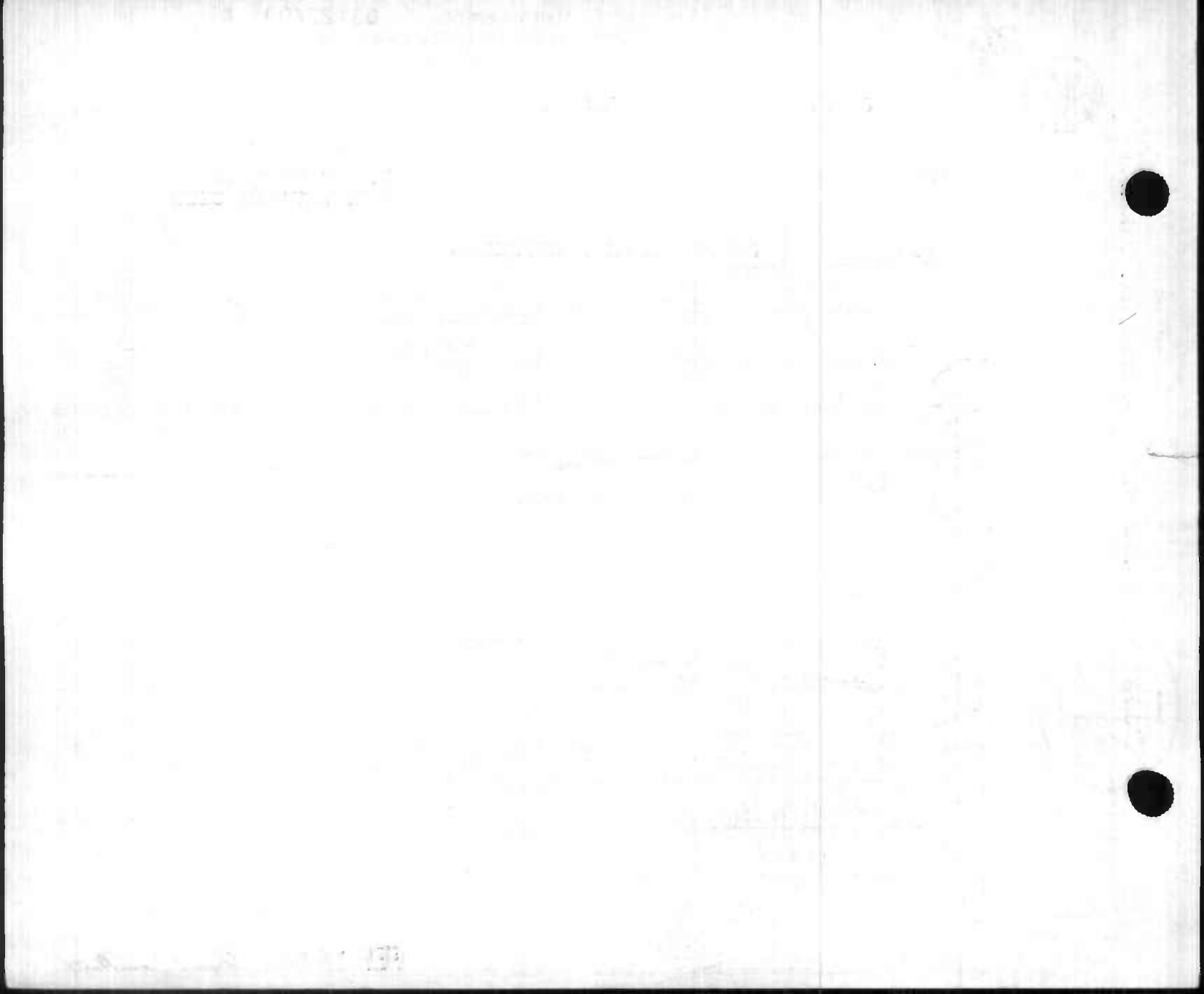
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours of death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

03/22/09 M 03 1 4 3

| | | | | | |
|---|---|---|---|-------------------------|-----------------------------------|
| 1. FOR STATE REGISTRAR | | 2a. DATE OF DEATH | | 2b. HOUR | |
| 1. DECEASED NAME
(TYPE OR PRINT) | | 2a. DATE OF DEATH | | 2b. HOUR | |
| JAMES GASQUE | | 2 - 11 - 82 | | 4:40 AM | |
| 3. SEX | 4. RACE | 5. DATE OF BIRTH | 6. AGE (IN YEARS LAST BIRTHDAY) | IF UNDER 1 YEAR | |
| Male | Black | 3 22 09 | 72 | IF UNDER 24 HRS. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) | 7b. CITIZEN OF WHAT COUNTRY? | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 9. BALTIMORE CITY OR COUNTY OF DEATH | | |
| S.C. | USA | | BALTIMORE CITY MD. | | |
| 10. CITY OR TOWN OF DEATH | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE) | | 12b. KIND OF BUSINESS OR INDUSTRY |
| Baltimore | JOHNS HOPKINS HOSPITAL | | | | |
| 13a. STATE | 13b. COUNTY | 13c. CITY OR TOWN | 13d. INSIDE CITY LIMITS? | 13e. STREET ADDRESS | |
| MD | | Baltimore | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | 633 Aisquith St. APT 8L | |
| 14. FATHER'S NAME | 15. MOTHER'S MAIDEN NAME | | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? | | |
| Gerly Gasque | Hattie Forks | | (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) | | |
| 16b. SOCIAL SECURITY NO. | 17. INFORMANT | | ADDRESS | | |
| 213-07-8316 | Mamie Gasque | | 633 Aisquith St. | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART 1. DEATH WAS CAUSED BY: | | | | | |
| IMMEDIATE CAUSE (a) <u>Cordic Arrest</u> | | | | | |
| 4149 DUE TO, OR AS A CONSEQUENCE OF | | | | | |
| (b) <u>Ischemic heart disease</u> | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF | | | | | |
| (c) _____ | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) | | | | | |
| 19a. DATE OF OPERATION | | | | | |
| 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | | |
| 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | |
| 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | | | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | | |
| 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | | | | |
| 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | | | |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | | | | |
| 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | | | | |
| 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 2-11 19 82, to 2-11 19 82, that (I) (we) lost saw the deceased alive on 2-11 19 82, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | |
| 22b. SIGNATURE DEGREE | | | | | |
| 22c. DATE SIGNED | | | | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) | | | | | |
| 22e. ADDRESS | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) | | | | | |
| 23b. DATE | | | | | |
| 23c. NAME OF CEMETERY OR CREMATORY | | | | | |
| 23d. LOCATION CITY OR TOWN COUNTY STATE | | | | | |
| 24. FUNERAL DIRECTOR NAME | | | | | |
| 25a. DATE REC'D. BY REGISTRAR | | | | | |
| 25b. REGISTRAR'S SIGNATURE | | | | | |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon copies. Pages 1 and 2 should be filed within 72 hours with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH | | | | 8 2 0 3 7 4 9 | | | |
|---|--|--|--|--|--|---|--|
| 1 - FOR STATE REGISTRAR | | | | REG. NO. | | | |
| 1 DECEASED NAME (TYPE OR PRINT) Gerald G. Gatewood | | | | 2a DATE OF DEATH MONTH DAY YEAR
February 13, 1982 | | 2b HOUR
7 A | |
| 3 SEX
Male | | 4 RACE
White | | 5 DATE OF BIRTH MONTH DAY YEAR
August 21, 1905 | | 6 AGE (IN YEARS LAST BIRTHDAY) MONTHS DAYS HOURS MIN.
76 | |
| 7a BIRTHPLACE (STATE OR FOREIGN COUNTRY)
Virginia | | 7b CITIZEN OF WHAT COUNTRY?
U.S.A. | | 8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9 BALTIMORE CITY OR COUNTY OF DEATH
Baltimore City MD | |
| 10 CITY OR TOWN OF DEATH
Baltimore | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN A HEALTH FACILITY, GIVE STREET ADDRESS)
3512 Poole Street | | 12a USUAL OCCUPATION (TYPE OR WORK FOR MOST OF WORKING LIFE)
Weaver | | 12b KIND OF BUSINESS OR INDUSTRY
Cotton Mill | |
| 13a STATE
Maryland | | 13b COUNTY
Baltimore | | 13c CITY OR TOWN
Baltimore | | 13d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 14 FATHER'S NAME FIRST MIDDLE LAST
John T. Gatewood | | | | 15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST
Ethel F. Fristoe | | | |
| 16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)
No | | 16b SOCIAL SECURITY NO.
213 10 4720A | | 17 INFORMANT
Fannie P. Gatewood | | ADDRESS
Same | |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY:
3320 Parbisonian
IMMEDIATE CAUSE (a) Parbisonian
DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b) _____
DUE TO, OR AS A CONSEQUENCE OF
(c) _____ | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | |
| 22a I certify that (I) (this hospital) attended the deceased from Aug 81 to Feb 13 1982 , that (I) (we) lost the deceased alive on 2/12 1982 , and not in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | |
| 22b. SIGNATURE Edward L. Glassman MD DEGREE | | | | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | 22c. DATE SIGNED 2/15/82 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
Dr. Edward L. Glassman | | | | 22e. ADDRESS
4037 Falls Road, Baltimore, Maryland | | | |
| 23a. BURIAL, CREMATION, REMOVAL
Burial | | 23b. DATE
15 Feb. 1982 | | 23c. NAME OF CEMETERY OR CREMATORY
Woodlawn Cemetery | | 23d. LOCATION CITY OR TOWN COUNTY STATE
Baltimore, Maryland | |
| 24 FUNERAL DIRECTOR NAME
Burgee Funeral Home | | | | ADDRESS
3631 Falls Rd. 21211 | | 25a. DATE REC'D. BY REGISTRAR
FEB 16 1982 | |
| | | | | 25b. REGISTRAR'S SIGNATURE
Thomas J. [Signature] | | | |

February 13, 1953

March 1, 1953

12

March 21, 1953

with

John

with

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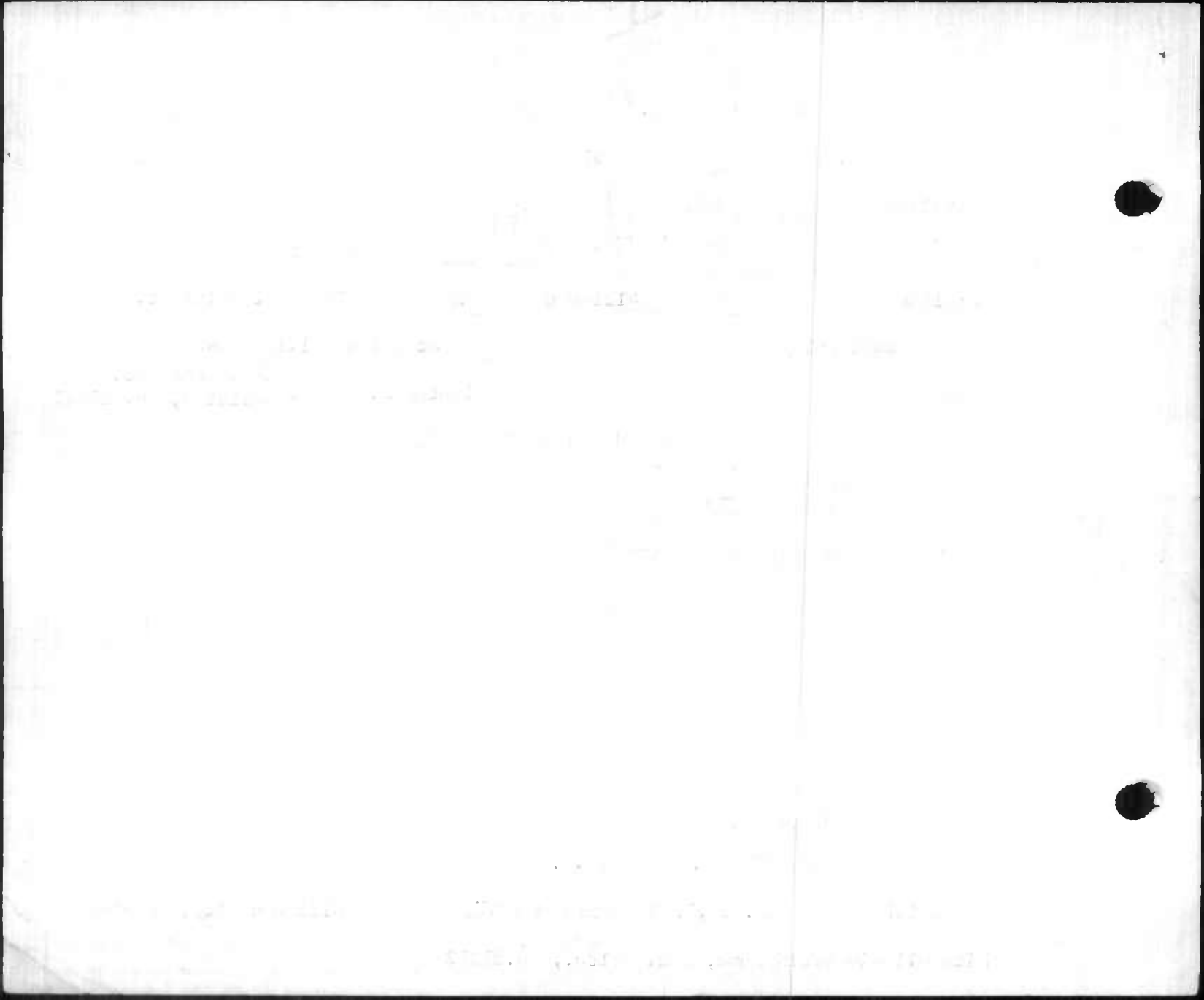
with

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

MEDICAL CERTIFICATION

| STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH | | | | | | | | | | REG. NO. 2 0 3 7 5 0 | | | | | |
|--|--|------------------|--|---|--|---|--|---|--|---|--|--|--|----|--|
| 1. DECEASED NAME
(TYPE OR PRINT) FIRST MIDDLE LAST
MARGARET M. GAULT | | | | | | | | | | 2a. DATE KNOWN OF DEATH
ESTIMATED
1-20-82 | | 2b. HOUR
M | | | |
| 3. SEX
female | | 4. RACE
white | | 5. DATE OF BIRTH
MONTH DAY YEAR | | 6. AGE (IN YEARS)
LAST BIRTHDAY
91 YRS. | | IF UNDER 1 YR.
MONTHS DAYS HOURS MIN. | | 2c. DATE PRONOUNCED DEAD
1-21-82 | | 2d. HOUR
7:31P
M | | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
Ireland | | | | 7b. CITIZEN OF WHAT COUNTRY?
USA | | | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | | | 9. BALTIMORE CITY OR COUNTY OF DEATH
Baltimore City | | MD | |
| 10. CITY OR TOWN OF DEATH
Baltimore | | | | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION
(IF IN NURSING HOME, GIVE STREET ADDRESS)
1706 Montpelier Street | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)
Homemaker | | | | 12b. KIND OF BUSINESS OR INDUSTRY | | | |
| USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) | | | | | | | | | | | | | | | |
| 13a. STATE
Maryland | | 13b. COUNTY | | 13c. CITY OR TOWN
Baltimore | | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS
1706 Montpelier St. | | | | | | | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
Edward Mulry | | | | | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
Katherine Collin Conway | | | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO, OR UNKNOWN)
No | | | | 16b. SOCIAL SECURITY NO. | | 17. INFORMANT
ADDRESS
Timothy J. Hughes 2105 Lamar Ct.
Fallston, Md. 21047 | | | | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I DEATH WAS CAUSED BY:
4292 IMMEDIATE CAUSE (a) Arteriosclerotic cardiovascular disease
Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.
(b) DUE TO, OR AS A CONSEQUENCE OF
(c) DUE TO, OR AS A CONSEQUENCE OF | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | | | | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I | | | | | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | | | | | | 20. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | |
| 21a. EXTERNAL CAUSE WAS
UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH | | | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) | | | | | | | | | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/> | | | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | | | | | | | |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> . | | | | | | | | | | | | | | | |
| ACTUAL SIGNATURE
Margarita A. Korell | | | | | | TITLE (SPECIFY)
Assistant | | M.D. MEDICAL EXAMINER | | DATE SIGNED
1-22-82 | | | | | |
| EXAMINER'S NAME
(TYPE OR PRINT) Margarita A. Korell, M.D. | | | | | | ADDRESS
111 Penn Street | | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)
Burial | | | | 23b. DATE
Feb. 20, 1982 | | 23c. NAME OF CEMETERY OR CREMATORY
New Cathedral | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
Baltimore City, Maryland | | | | | | | |
| 24. FUNERAL DIRECTOR
NAME
Mitchell-Wiedefeld Home, Inc. Balto., Md. 21212 | | | | | | ADDRESS
6500 York Rd. | | 25a. DATE REC'D. BY REGISTRAR
MAR 1 1982 | | 25b. REGISTRAR'S SIGNATURE | | | | | |

BP



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use on the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| FOR
1- STATE
REGISTRAR | | STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH | | 8 2 0 3 7 5 1
REG. NO. | |
|---|--|--|--|--|--|
| 1. DECEASED NAME
(TYPE OR PRINT) <u>Gelbstein, SARA</u> | | 2a. DATE OF DEATH MONTH <u>02</u> DAY <u>16</u> YEAR <u>82</u> | | 2b. HOUR <u>10 50 AM</u> | |
| 3. SEX <u>FEMALE</u> | 4. RACE <u>WHITE</u> | 5. DATE OF BIRTH <u>15 JAN 21 02</u> | | 6. AGE (IN YEARS LAST BIRTHDAY) <u>80 79</u> YRS | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <u>Russia</u> | 7b. CITY OR TOWN AND COUNTRY? <u>Russia</u> | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH <u>Baltimore, City</u> MD. | |
| 10. CITY OR TOWN OF DEATH <u>Baltimore</u> | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <u>Simon Hospital</u> | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <u>HOUSEWIFE</u> | | 12b. KIND OF BUSINESS OR INDUSTRY <u>AT HOME</u> |
| 13a. STATE <u>MARYLAND</u> | | 13b. COUNTY <u>BALTO.</u> | 13c. CITY OR TOWN <u>BALTIMORE</u> | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 14. FATHER'S NAME FIRST <u>LAZER</u> MIDDLE <u>VRONSBURG</u> LAST <u>RACHEL</u> | | 15. MOTHER'S MAIDEN NAME FIRST <u>RACHEL</u> MIDDLE <u>UNKNOWN</u> LAST <u>UNKNOWN</u> | | 16. SOCIAL SECURITY NO. <u>217-96-2864</u> | |
| 17. INFORMANT <u>HEBREW BURIAL & SOC. SERVICE</u> | | 18. ADDRESS <u>1330 REISTERSTOWN RD.</u> | | 19. CITY <u>BALTO.</u> STATE <u>MD</u> ZIP <u>21208</u> | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART 1. DEATH WAS CAUSED BY:
<u>4100</u> IMMEDIATE CAUSE (a) <u>Cerebral aneurysm</u>
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last:
(b) <u>Myocardial infarction</u>
(c) <u>A SCVD</u> | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:
<u>None</u> | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. <u>19</u> | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION CITY OR TOWN COUNTY STATE | |
| 22a. I certify that (1) (the hospital) attended the deceased from <u>2/13</u> 19 <u>82</u> , to <u>2/16</u> 19 <u>82</u> , that (1) (we) last saw the deceased alive on <u>2/16</u> 19 <u>82</u> , and that in my (our) opinion death occurred on the date and hour and from the causes stated above, (1) (we) (did) (did not) view the body after death. | | | | | |
| 22b. SIGNATURE <u>J. Gabay</u> DEGREE <u>MD</u> | | 22c. ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> | | 22d. DATE SIGNED <u>2/16/82</u> | |
| 22e. PHYSICIAN'S NAME (TYPE OR PRINT) <u>J. GABAY</u> | | 22f. ADDRESS <u>Simon Hospital</u> | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>BURIAL</u> | | 23b. DATE <u>FEB. 17, 1982</u> | | 23c. NAME OF CEMETERY OR CREMATORY <u>BALTO. HEBREW</u> | |
| 23d. LOCATION <u>BALTIMORE</u> | | 23e. COUNTY <u>MARYLAND</u> | | | |
| 24. FUNERAL DIRECTOR NAME <u>SOL LEVINSON & BROS., INC.</u> | | 24b. ADDRESS <u>6010 REISTERSTOWN RD. BALTO., MD 21215</u> | | 25a. DATE REC'D BY REGISTRAR <u>FEB 24 1982</u> | |
| 25b. REGISTRAR'S SIGNATURE <u>Thomas J. North</u> | | | | | |

100 48 1374

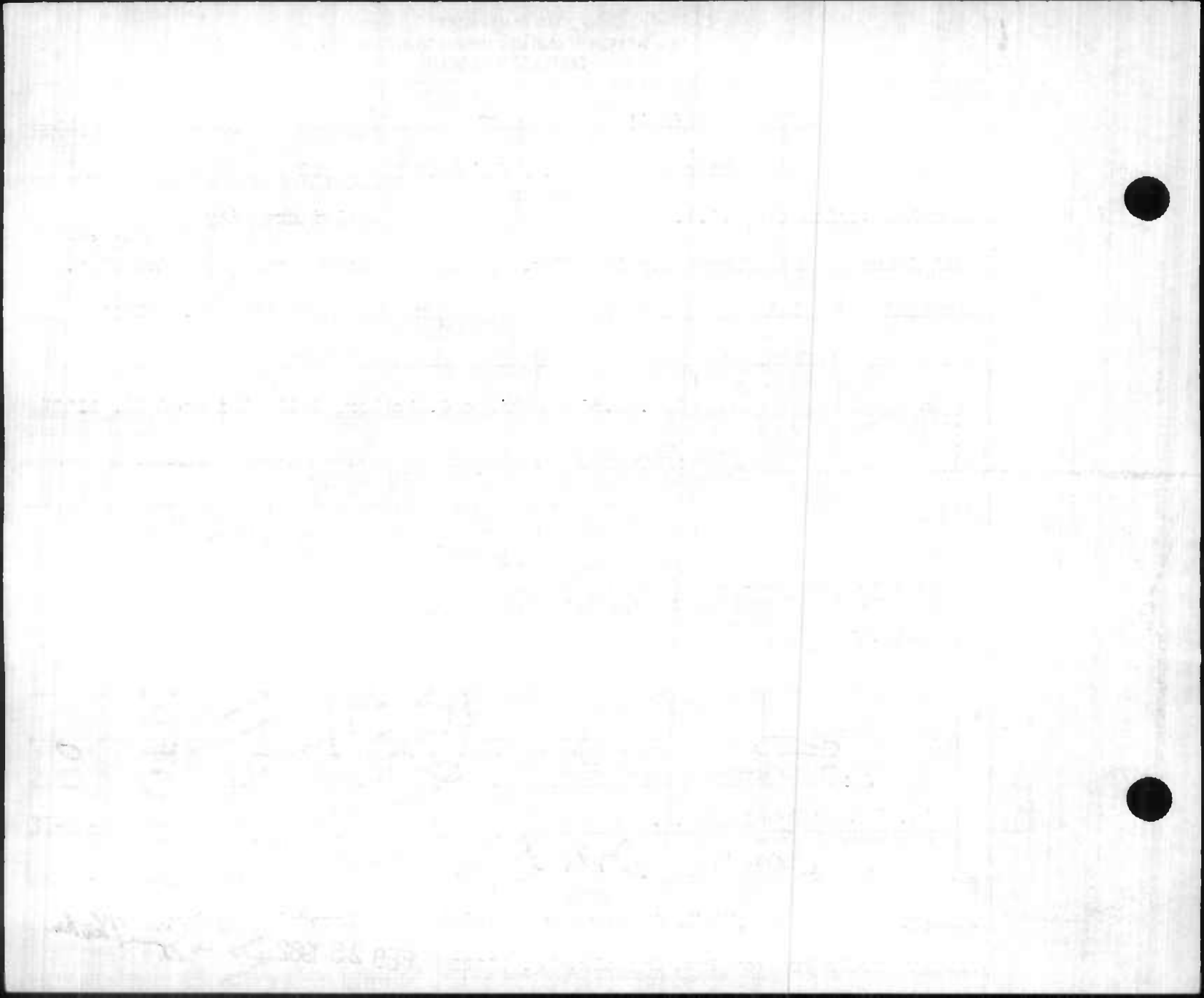
STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 2 0 3 7 5 2

1. FOR
STATE
REGISTRAR

REG. NO.

| | | | | | |
|---|--|---|---|--|---|
| 1. DECEASED NAME
(TYPE OR PRINT)
ELMER (nmi) GEORGE | | | 7a. DATE OF DEATH
MONTH DAY YEAR
02-24-82 | | 7b. HOUR
9:40pm |
| 3. SEX
Male | 4. RACE
White | 5. DATE OF BIRTH
MONTH DAY YEAR
2 / 6 / 1900 | | 6. AGE (IN YEARS LAST BIRTHDAY)
82 YRS. | IF UNDER 1 YEAR
MONTHS DAYS HOURS MIN. |
| 7a. BIRTHPLACE
(STATE OR FOREIGN COUNTRY)
Cleveland, Ohio | 7b. CITIZEN OF WHAT COUNTRY?
U.S.A. | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
Baltimore City MD. | |
| 10. CITY OR TOWN OF DEATH
Baltimore | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
Church Hospital Inc. | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
Batch Man | 12b. KIND OF BUSINESS OR INDUSTRY
Rod Mfrg. | |
| 13a. STATE
Maryland | 13b. COUNTY
Baltimore | 13c. CITY OR TOWN
Dundalk | 13d. INSIDE CITY LIMITS?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | 13e. STREET ADDRESS
243 Colgate Ave. 21222 | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
UNKNOWN | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
UNKNOWN | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
No | 16b. SOCIAL SECURITY NO.
(IF YES, GIVE WAR OR DATES)
236.22.6850 | 17. INFORMANT
ADDRESS
Wilma J. Webber 1813 Ellinwood Rd. 21237 | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART 1. DEATH WAS CAUSED BY:
5789 IMMEDIATE CAUSE (a) RENAL FAILURE
DUE TO, OR AS A CONSEQUENCE OF
POST OPERATIVE GASTROSTOMY FOR GASTROINTESTINAL BLEEDING
DUE TO, OR AS A CONSEQUENCE OF
CHRONIC OBSTRUCTIVE PULMONARY DISEASE
TRACHEOTOMY, ARTERIOSCLEROTIC HEART DISEASE | | | | | APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATH |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:
CHRONIC OBSTRUCTIVE PULMONARY DISEASE | | | | | |
| 19a. DATE OF OPERATION
02-18-82 | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED
MASSIVE GASTROINTESTINAL BLEEDING | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | 20b. IF YES, WERE FINDINGS USED
IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK AT WORK | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | |
| 22a. I certify that (I) (this hospital) attended the deceased from 02-05- 19 82 , to 02-24- 19 82 , that (I) <input checked="" type="checkbox"/> saw the deceased alive on 02-24- 19 82 , and that in (my) <input checked="" type="checkbox"/> opinion death occurred on the date and hour and from the causes stated above, (I) <input checked="" type="checkbox"/> did not view the body after death. | | | | | |
| 22b. SIGNATURE
DR. PRASAD SOMPALLI M.D. | | DEGREE | | 22c. DATE SIGNED
02-24-82 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
Sompalli Prasad | | 22e. ADDRESS
CHURCH HOSPITAL CORPORATION
100 N. BROADWAY BALTIMORE, MARYLAND 21231 | | | |
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)
Burial | 23b. DATE
2/27/1982 | 23c. NAME OF CEMETERY OR CREMATORY
Gardens of Faith | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
Rosedale Balto. Md. | |
| 24. FUNERAL DIRECTOR
NAME ADDRESS
Walter Brooks Bradley Inc. Dundalk, Md. 21222 | | 25a. DATE REC'D. BY REGISTRAR
FEB 25 1982 | | | |



STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

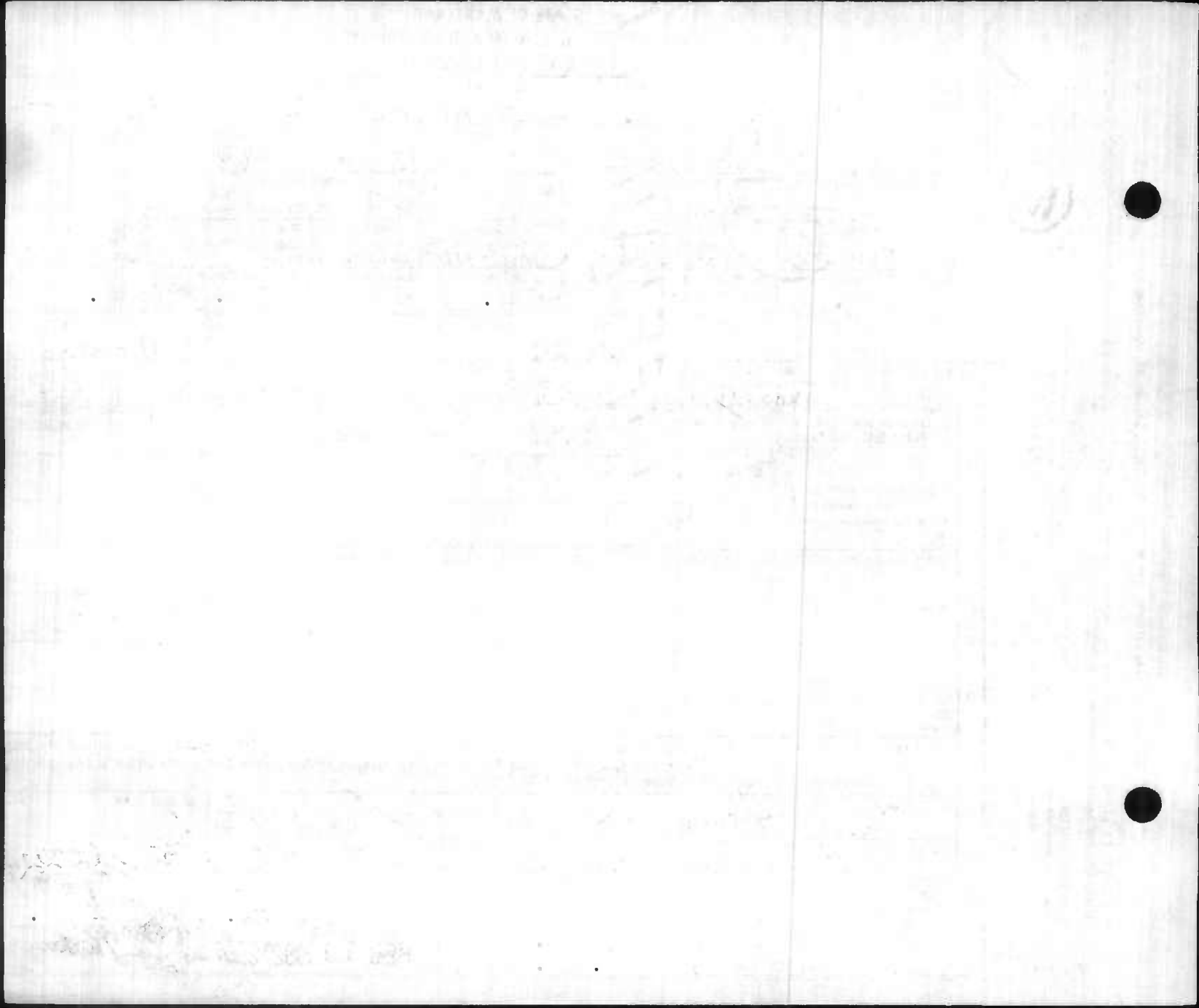
03753

| | | | | | |
|--|---|---|---|--|--|
| 1. DECEASED-NAME
(Type or print) Andrew B. Gernhardt | | | 2a. DATE OF DEATH
2 Month 18 Day 82 Year | | 2b. HOUR
— M |
| 3. SEX
Male | 4. RACE
Caucasian | 5. DATE OF BIRTH
2-13-14 | | 6. AGE (In years last birthday)
68 YRS. | IF UNDER 1 YEAR
MONTHS DAYS
IF UNDER 24 HRS.
HOURS MIN. |
| 7a. BIRTHPLACE (State or foreign country)
Md. | 7b. CITIZEN OF WHAT COUNTRY?
U.S.A. | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/> | 9. COUNTY OF DEATH
Baltimore City Md. | | |
| 10. CITY OR TOWN OF DEATH
Baltimore | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)
Grande Nursing Home 7017 Liberty Hts. Ave. 21207 | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)
Carpenter | 12b. KIND OF BUSINESS OR INDUSTRY worked
Independently | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE
Md. | 13b. COUNTY
Balto. | 13c. CITY OR TOWN
Balto. | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | 13e. STREET AND NUMBER
7033 E. Bank St. | |
| 14. FATHER'S NAME First Middle Last
George Gernhardt | | 15. MOTHER'S MAIDEN NAME First Middle Last
Rose MENKIE | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)
yes | | 16b. SOCIAL SECURITY NO.
216-09-1963 | 17. INFORMANT Address
Edward Gernhardt - 7033 E. Bank St. 21224 | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
4100 IMMEDIATE CAUSE (a) Colonial Thromboses
DUE TO, OR AS A CONSEQUENCE OF ASCD
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b) _____ DUE TO, OR AS A CONSEQUENCE OF _____
(c) _____ | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner) | | 21b. TIME OF INJURY
HOUR A.M. Month Day Year
P.M. 19 | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | |
| 21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> | | 21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.) | | 21f. LOCATION Street or R.F.D. No. City or Town County State | |
| 22a. I certify that (I) (this hospital) attended the deceased from 1/4/79 , 19____, to 2/8/82 , 19____, that (I) (we) last saw the deceased alive on 2/4/82 , 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | |
| 22b. SIGNATURE
[Signature] | | DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> | | 22c. DATE SIGNED | |
| 22d. PHYSICIAN'S NAME (Type)
HORNS DEGNAXNE, MD | | 22e. ADDRESS
5010 Jinx Rd, Dr. Md 21222 | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) | 23b. DATE
2/20/82 | 23c. NAME OF CEMETERY OR CREMATORY
Gardens of Faith | | 23d. LOCATION (City or Town) (County) (State)
Balto. Md. | |
| 24. FUNERAL HOME (Type)
Continuum Funeral Home, Inc. | | ADDRESS
3331 Brehms Lane, Balto. Md. 21213 | | 25a. REC'D BY REGISTRAR
FEB 19 1982 | 25b. REGISTRAR'S SIGNATURE
[Signature] |

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be retained by the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal, and in any event, within 12 hours after death.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

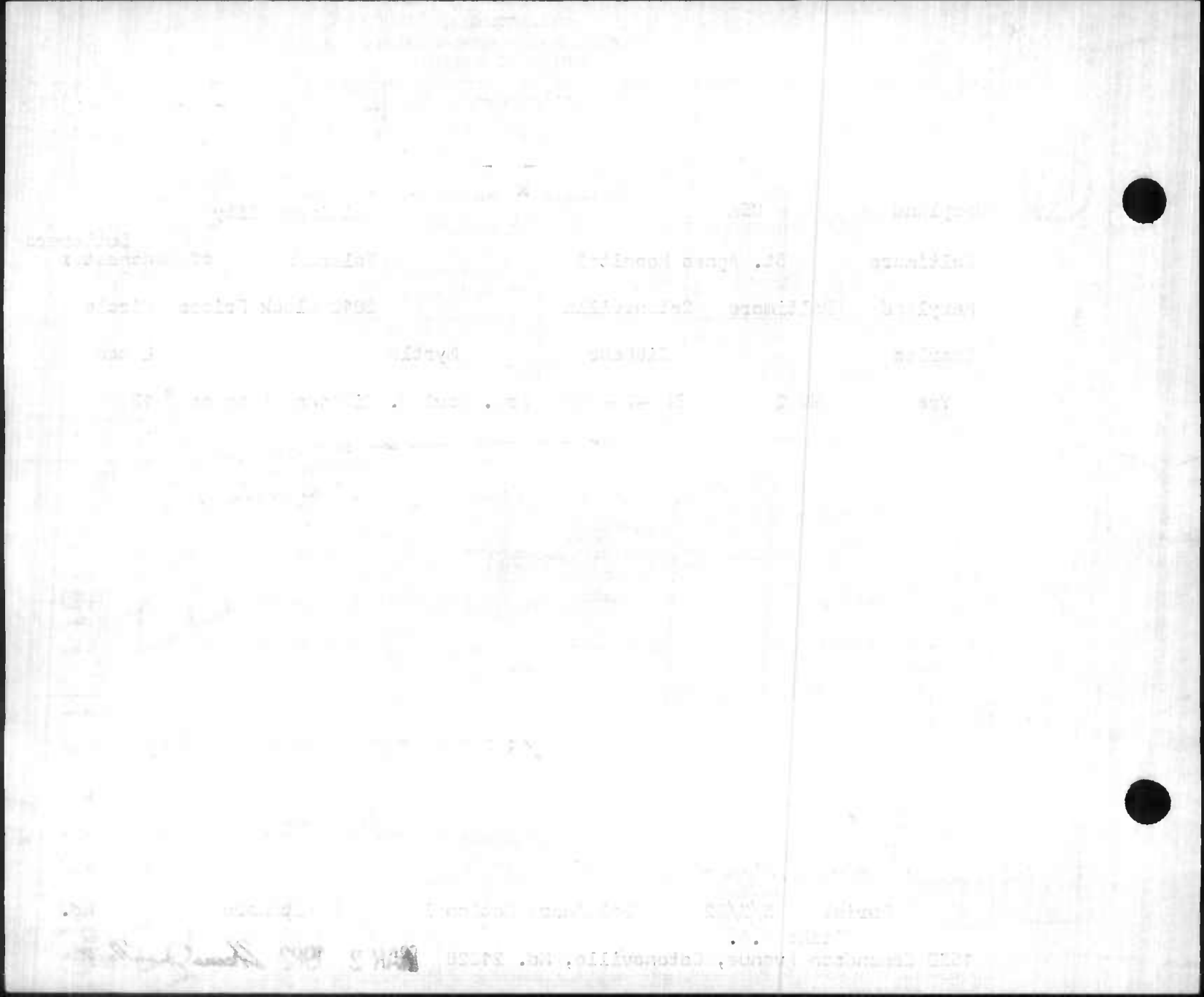
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the death certificate with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

| STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH | | | | | | | | | | 8 2 0 3 7 5 4 | |
|--|--|--|--|---|--|--|--|--|--|---|--|
| 1. FOR STATE REGISTRAR | | REG. NO. | | | | | | | | | |
| 1. DECEASED NAME (TYPE OR PRINT) | | FIRST
Paul | | MIDDLE
C | | LAST
Gibbons | | 2a. DATE OF DEATH | | MONTH DAY YEAR
2-28-82 | |
| 3. SEX
Male | | 4. RACE
White | | 5. DATE OF BIRTH
MONTH DAY YEAR
7-05-17 | | 6. AGE (IN YEARS LAST BIRTHDAY)
64 YRS | | 7b. HOUR
4:50PM | | M | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
Maryland | | 7b. CITIZEN OF WHAT COUNTRY?
USA | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
Baltimore City | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)
Salesman | | 12b. KIND OF BUSINESS OR INDUSTRY
Outfitters of Manchester | |
| 10. CITY OR TOWN OF DEATH
Baltimore | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
St. Agnes Hospital | | 13a. STATE
Maryland | | 13b. COUNTY
Baltimore | | 13c. CITY OR TOWN
Catonsville | | 13d. INSIDE CITY LIMITS?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
Charles Gibbons | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
Myrtle Linde | | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)
Yes | | 16b. SOCIAL SECURITY NO.
WW 2 215-09-5834 | | 17. INFORMANT
Mrs. Paul C. Gibbons | | ADDRESS
Same as # 13 | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART 1. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>Cardiac arrest.</u>
<u>4100</u>
DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (b), stating the underlying cause lost.
(b) <u>acute myocardial infarction</u>
DUE TO, OR AS A CONSEQUENCE OF
(c) _____ | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a) _____ | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | | | | | |
| 21d. INJURY OCCURRED
WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>2/28</u> , 19 <u>82</u> , to <u>2/28</u> , 19 <u>82</u> , that (I) (we) lost saw the deceased alive on <u>2/28</u> , 19 <u>82</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | | | |
| 22b. SIGNATURE
<u>Ricardo Machado</u> | | | | | | DEGREE
ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> | | 22c. DATE SIGNED | | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
<u>RICARDO MACHADO M.D.</u> | | | | | | 22e. ADDRESS
<u>St Agnes Hospital Balt. MD.</u> | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)
Burial | | 23b. DATE
3/3/82 | | 23c. NAME OF CEMETERY OR CREMATORY
Baltimore National | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
Baltimore Md. | | | | | |
| 24. FUNERAL DIRECTOR
NAME
Witzke P.A.
1630 Edmondson Avenue, Catonsville, Md. 21228 | | | | | | 25a. DATE REC'D. BY REGISTRAR
MAR 2 1982 | | 25b. REGISTRAR'S SIGNATURE
<u>Thomas J. Smith</u> | | | |



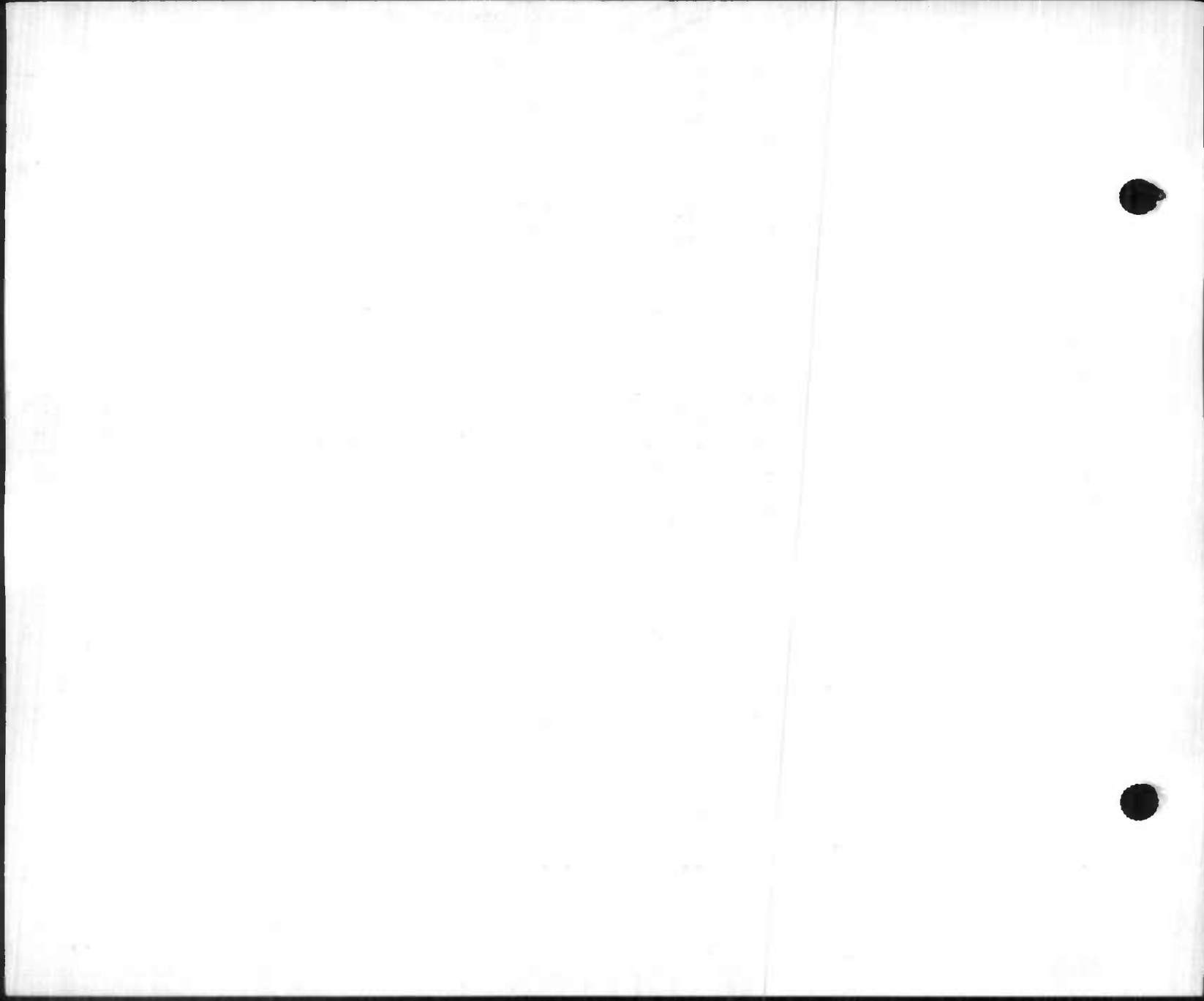
REG. NO.

BP_____

DMMH-17

VR A15 ME (5)

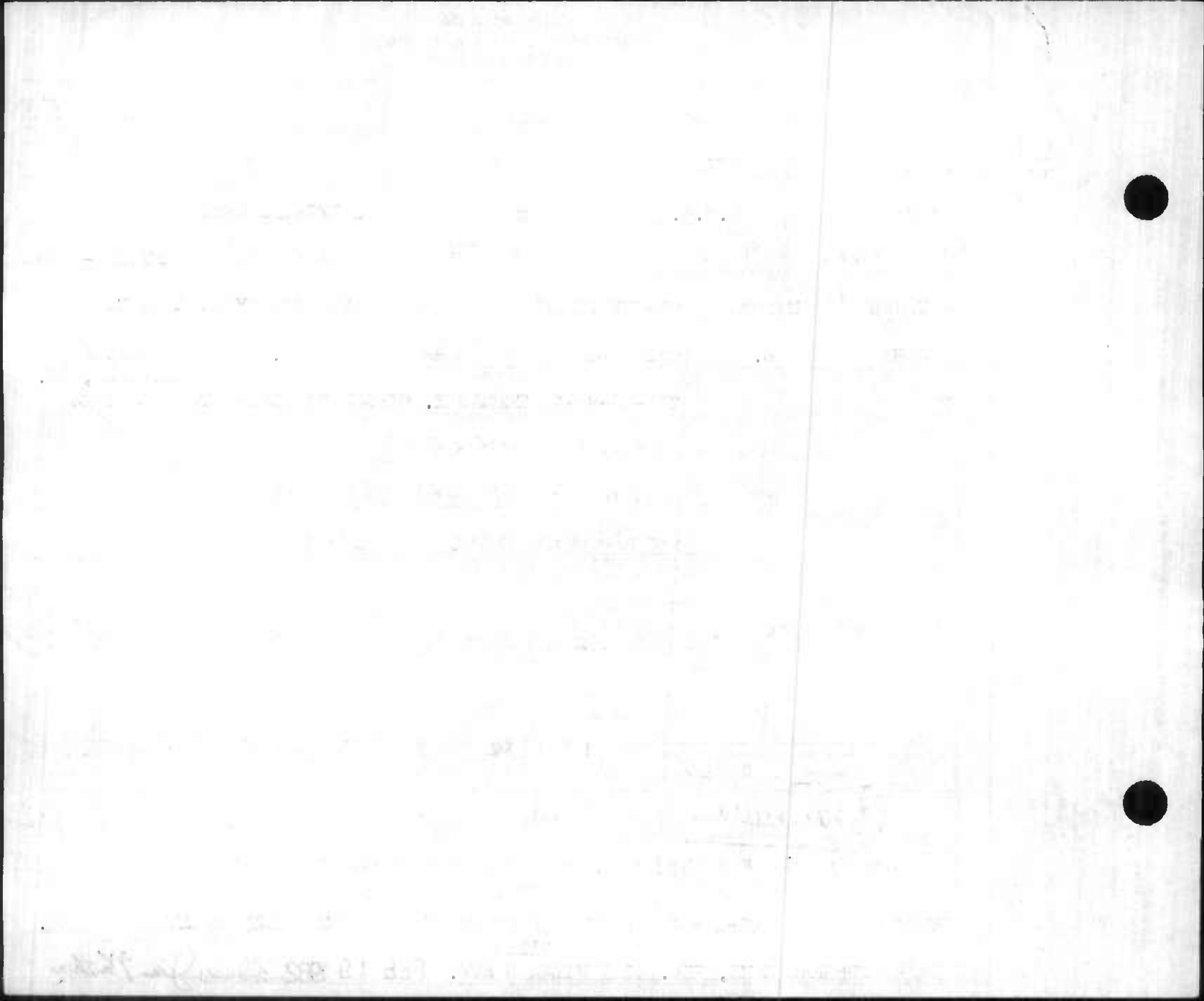
15M2/80



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the Department of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

| STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH | | | | | | | | | | REG. NO. | |
|--|--|---|--|---|--|--|--|--|--|--|--|
| 1. DECEASED NAME
(TYPE OR PRINT)
FIRST MIDDLE LAST
ALVINA LOIS GIBSON | | | | | | 2a. DATE OF DEATH
MONTH DAY YEAR
02 15 82 | | 2b. HOUR
18 15 HRS
M | | | |
| 3. SEX
FEMALE | | 4. RACE
WHITE | | 5. DATE OF BIRTH
MONTH DAY YEAR
05 06 21 | | 6. AGE (IN YEARS LAST BIRTHDAY)
60 YRS. | | IF UNDER 1 YEAR
MONTHS DAYS
IF UNDER 24 HRS.
HOURS MIN. | | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
MARYLAND | | 7b. CITIZEN OF WHAT COUNTRY?
U.S.A. | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
BALTIMORE CITY MD. | | | | | |
| 10. CITY OR TOWN OF DEATH
BALTIMORE | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS
ST. AGNES HOSPITAL | | | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
SALESPERSON | | 12b. KIND OF BUSINESS OR INDUSTRY
RETAIL - FURS | | | |
| 13a. STATE
MARYLAND | | | | 13b. COUNTY
BALTIMORE | | 13c. CITY OR TOWN
COCKEYSVILLE | | 13d. INSIDE CITY LIMITS?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
JOHN E. CALDWELL | | | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
EMMA E. DEWELL | | | | 16. ADDRESS
COCKEYSVILLE, MD. | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
NO | | 16b. SOCIAL SECURITY NO.
(IF YES, GIVE WAR OR DATES)
217-16-8512 | | 17. INFORMANT
THOMAS I. GIBSON 321 LORD BYRON LANE T4 | | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART 1. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>CARDIAC ARREST</u>
<u>5570</u>
DUE TO, OR AS A CONSEQUENCE OF:
(b) <u>INTRA ABDOMINAL SEPSIS</u>
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last
(c) <u>GANGRENOUS ILEUM</u>
DUE TO, OR AS A CONSEQUENCE OF:
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| 19a. DATE OF OPERATION
<u>1/31/82 + 2/12/82</u> | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED
<u>GANGRENOUS SMALL INTESTINE ILEUM</u> | | | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | | | | | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK AT WORK | | 21e. PLACE OF INJURY
(AT HOME STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | | | | | |
| 22a. I certify that (this hospital) attended the deceased from <u>01/31/82</u> , 19 <u>82</u> , to <u>02/15</u> , 19 <u>82</u> , that (we) lost the deceased alive on <u>02/15</u> , 19 <u>82</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | | | |
| 22b. SIGNATURE
<u>[Signature]</u> | | | | DEGREE
<u>MD</u>
ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> | | | | 22c. DATE SIGNED
<u>02/15/82</u> | | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
RICHARD G. RAJARATNAM | | | | 22e. ADDRESS
900 S CATON AVE. BALTIMORE MD 21229 | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)
BURIAL | | 23b. DATE
02-18-82 | | 23c. NAME OF CEMETERY OR CREMATORY
OAK LAWN CEMETERY | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
EAST POINT BALTIMORE MD. | | | | | |
| 24. FUNERAL DIRECTOR
NAME
HUBBARD FUNERAL HOME, INC. | | | | ADDRESS
4107 WILKENS AVE. | | 25a. DATE REC'D. BY REGISTRAR
FEB 19 1982 | | 25b. REGISTRAR'S SIGNATURE
<u>[Signature]</u> | | | |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at 1-800-368-1234.

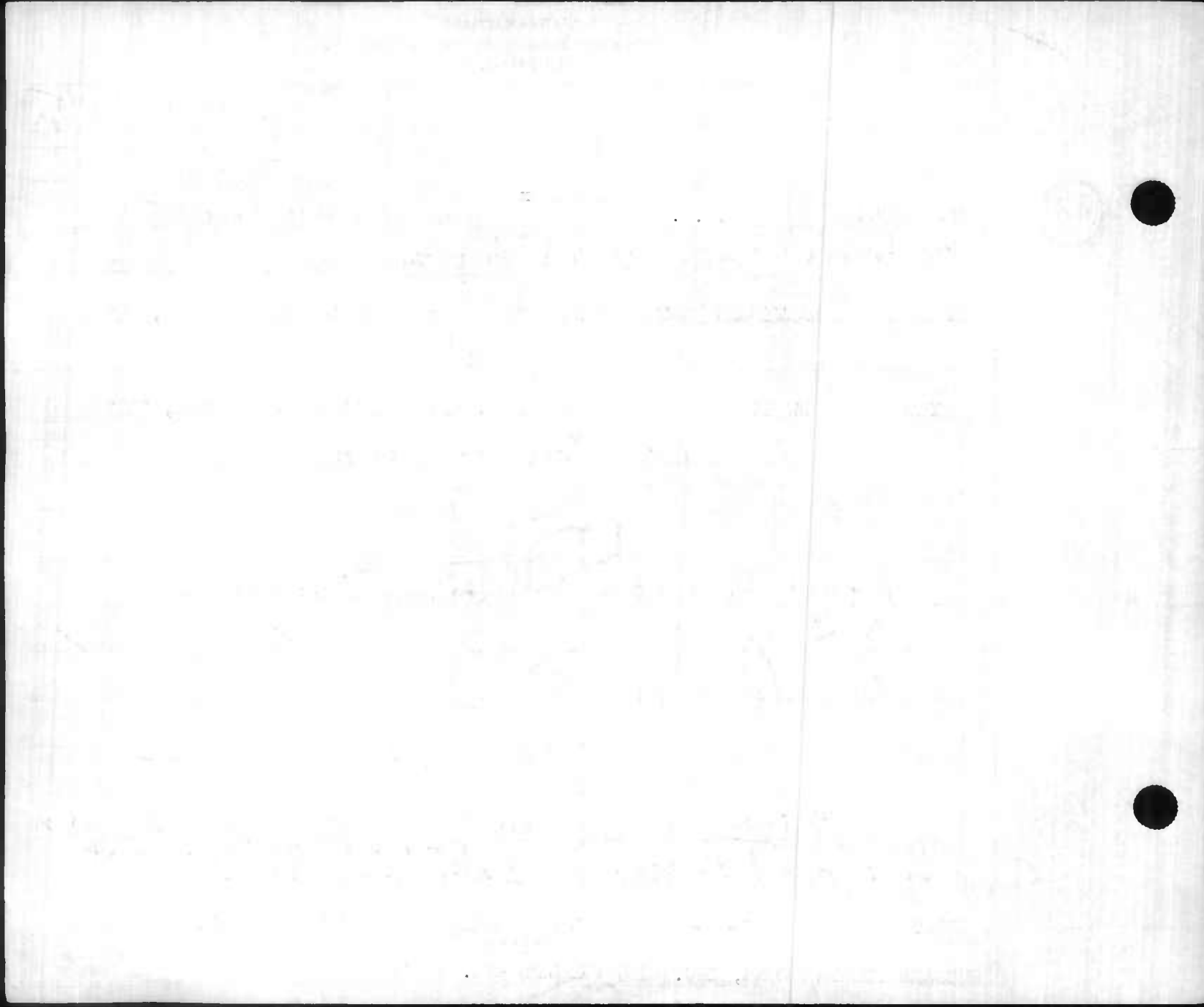
| STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH | | | | | | | | | | REG. NO. | |
|--|--|---|--|---|--|--|--|--|--|---------------|--|
| 1. FOR STATE REGISTRAR | | | | | | | | | | 8 2 0 3 1 5 1 | |
| 1. DECEASED NAME (TYPE OR PRINT)
FIRST MIDDLE LAST
Joseph — Gilberto | | | | | 2a. DATE OF DEATH
MONTH DAY YEAR
2 13 82 | | | 2b. HOUR
12:20 P.M. | | | |
| 3. SEX
MALE | | 4. RACE
W | | 5. DATE OF BIRTH
MONTH DAY YEAR
11 05 05 | | 6. AGE (IN YEARS LAST BIRTHDAY)
76 YRS. | | IF UNDER 1 YEAR
MONTHS DAYS HOURS MIN. | | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
Italy | | 7b. CITIZEN OF WHAT COUNTRY?
Italy | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
BALTIMORE CITY MD. | | | | | |
| 10. CITY OR TOWN OF DEATH
Baltimore | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
St. Agnes Hospital | | | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
Wholesale Produce | | 12b. KIND OF BUSINESS OR INDUSTRY | | | |
| 13a. STATE
Maryland | | 13b. COUNTY
Baltimore | | 13c. CITY OR TOWN
Catonsville | | 13d. INSIDE CITY LIMITS?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 13e. STREET ADDRESS
6002 Sherrill Road | | | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
Augustino = Gilberto | | | | 15. MOTHER'S MAIDEN NAME
MIDDLE LAST
Philamino = Tringali | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
no | | 16b. SOCIAL SECURITY NO.
217-03-8903 | | 17. INFORMANT
Rose Gilberto | | ADDRESS
same as above | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART 1. DEATH WAS CAUSED BY:
4310 IMMEDIATE CAUSE (a) <u>Intra cerebral hemorrhage</u>
DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b) _____
DUE TO, OR AS A CONSEQUENCE OF
(c) _____
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
48h | | | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | | | | | |
| 21d. INJURY OCCURRED
WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>2-11</u> , 19 <u>82</u> , to <u>2-13</u> , 19 <u>82</u> , that (I) (we) last saw the deceased alive on <u>2-13</u> , 19 <u>82</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | | | |
| 22b. SIGNATURE
<u>Lawrence Zeidman</u> | | | | DEGREE
MD | | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | 22c. DATE SIGNED
2-13-82 | | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
DR. Lawrence Zeidman | | | | 22e. ADDRESS | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)
Burial | | 23b. DATE
2/16/82 | | 23c. NAME OF CEMETERY OR CREMATORY
Lakeview Mem. Pk. | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
Sykesville, Carroll, Md. | | | | | |
| 24. FUNERAL DIRECTOR
NAME
Raymond C. Fink | | | | ADDRESS
Glen Burnie, Md. | | 25a. DATE REC'D. BY REGISTRAR
FEB 18 1982 | | 25b. REGISTRAR'S SIGNATURE
<u>James Van Nether</u> | | | |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
(IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.)

| STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH | | | | | | | | | | 8 2 0 3 / 5 8 | |
|---|--|--|--|---|--|---|--|---|--|---------------|--|
| 1. FOR STATE REGISTRAR | | REG. NO. | | | | | | | | | |
| 1. DECEASED NAME (TYPE OR PRINT)
FIRST MIDDLE LAST
CHARLES EDWARD GILES | | | | | | 2a. DATE OF DEATH
MONTH DAY YEAR
2-13-82 | | 2b. HOUR
MIN.
1:45 PM | | | |
| 3. SEX
MALE | | 4. RACE
WHITE | | 5. DATE OF BIRTH
MONTH DAY YEAR
02 06 27 | | 6. AGE (IN YEARS LAST BIRTHDAY)
55 YRS. | | 7. IF UNDER 1 YEAR
MONTHS DAYS HOURS MIN. | | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
TENNESSEE | | 7b. CITIZEN OF WHAT COUNTRY?
U.S.A. | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
Baltimore MD. | | | | | |
| 10. CITY OR TOWN OF DEATH
Baltimore | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
Univ. of MD Hospital | | | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
SALESMAN | | 12b. KIND OF BUSINESS OR INDUSTRY
FURNITURE & APPLIANCES | | | |
| 13a. STATE
MARYLAND | | 13b. COUNTY
BALTIMORE | | 13c. CITY OR TOWN
CATONSVILLE | | 13d. INSIDE CITY LIMITS?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 13e. STREET ADDRESS
1023 COLLWOOD ROAD, 21228 | | | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
CHARLIE GILES | | | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
MINNIE BROWN | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
YES | | 16b. SOCIAL SECURITY NO.
WW II 415-32-4853 | | 17. INFORMANT
ADDRESS
OPAL GILES 1023 COLLWOOD ROAD, 21228 | | | | | | | |
| 18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c).
PART 1. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) OAT CELL CARCINOMA
1629
DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b) _____
DUE TO, OR AS A CONSEQUENCE OF
(c) _____ | | | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a):
Chronic Obstructive Pulmonary Disease | | | | | | | | | | | |
| 19a. DATE OF OPERATION
N/A | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF OTHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | | | | | |
| 21d. INJURY OCCURRED
WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 2-13-82 to 2-13-82 . That (I) (we) last saw the deceased alive on 2-13-82 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) sign the body after death. | | | | | | | | | | | |
| 22b. SIGNATURE
Hubbard V. Reddy | | | | DEGREE
MD
ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | | | 22c. DATE SIGNED
2-13-82 | | | |
| 22d. PHYSICIAN'S NAME (PRINT)
Hubbard V. Reddy | | | | 22e. ADDRESS
B-C-R-C, 22 S Greene St
Balto, MD, 21207 | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)
BURIAL | | 23b. DATE
02-17-82 | | 23c. NAME OF CEMETERY OR CREMATORY
LOUDON PARK | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
BALTIMORE CITY MARYLAND | | | | | |
| 24. FUNERAL DIRECTOR
NAME
HUBBARD FUNERAL HOME, INC. | | | | ADDRESS
4107 WILKENS AVE. 21229 | | 25a. DATE REC'D. BY REGISTRAR
FEB 16 1982 | | 25b. REGISTRAR'S SIGNATURE
Thome Jan Norton | | | |



STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 2 0 3 7 5 9

1. FOR
STATE
REGISTRAR

REG. NO.

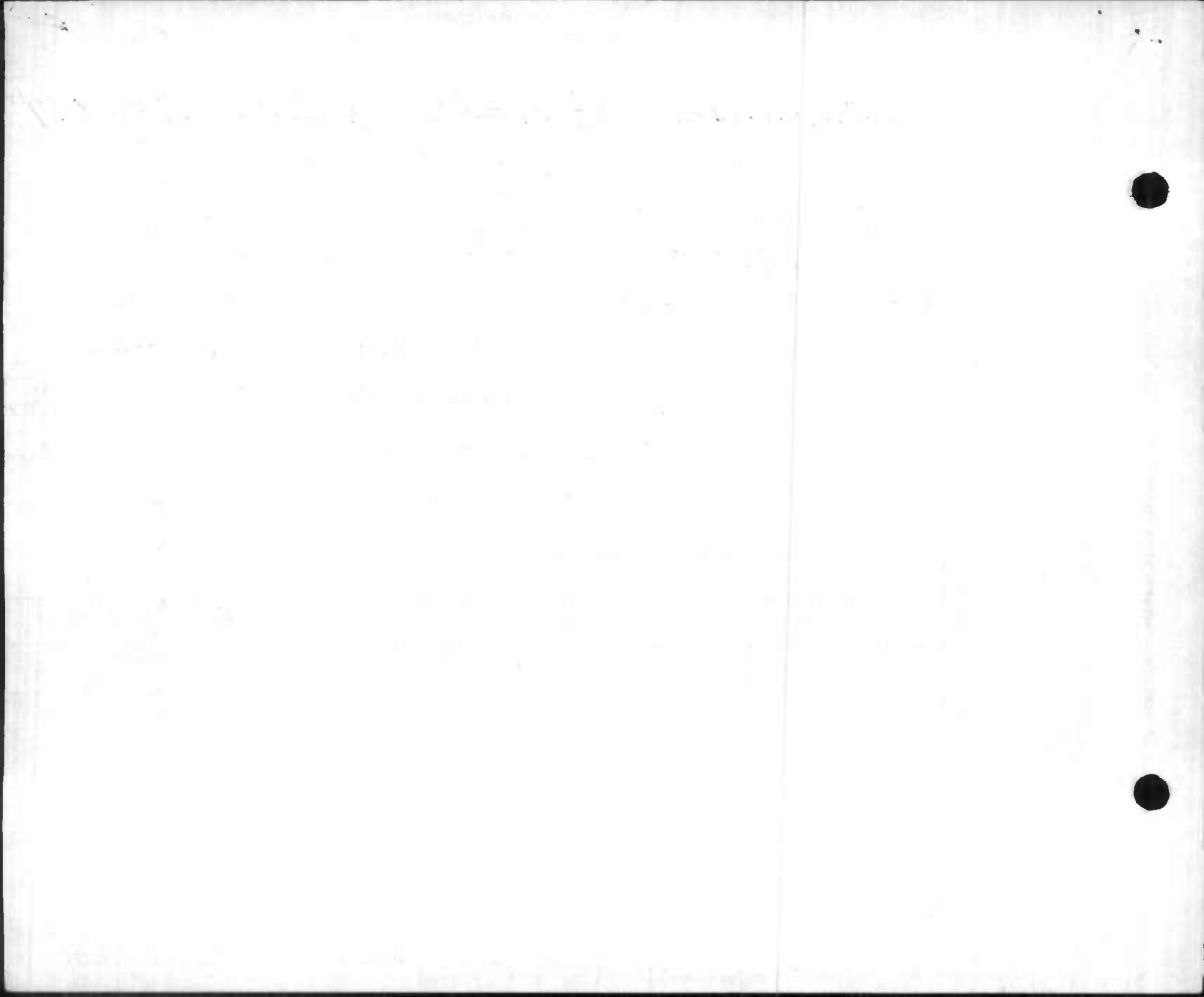
| | | | | | |
|---|---|---|---|--|--|
| 1. DECEASED NAME
(TYPE OR PRINT) Catherine Givens | | | 2a. DATE OF DEATH
MONTH DAY YEAR
Feb. 22, 1982 | | 2b. HOUR
MIN.
8:37 A.M. |
| 3. SEX
Female | 4. RACE
Black | 5. DATE OF BIRTH
MONTH DAY YEAR
7/6/1911 | | 6. AGE (IN YEARS LAST BIRTHDAY)
YRS. MONTHS DAYS HOURS MIN.
70 | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
Virginia | 7b. CITIZEN OF WHAT COUNTRY?
U.S.A. | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
Baltimore, Md. | |
| 10. CITY OR TOWN OF DEATH
Balt. City | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
3800 W. Belvedere | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
Housewife | | 12b. KIND OF BUSINESS OR INDUSTRY |
| 13a. STATE
Md. | | 13b. COUNTY
North City | 13c. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | 13d. STREET ADDRESS
3800 W. Belvedere | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
Elizabeth Newton | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
Shirley Bridges | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN) <input type="checkbox"/> IF YES, GIVE WAR OR DATES | | 16b. SOCIAL SECURITY NO.
218-26-1975 | | 17. INFORMANT
ADDRESS
3701 Oakmont | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART 1. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Cardiopulmonary arrest
4140
DUE TO, OR AS A CONSEQUENCE OF:
(b) Coronary vascular disease
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.
(c) | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a): | | | | | |
| 19a. DATE OF OPERATION
— | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED
— | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)
— | |
| 21d. INJURY OCCURRED
WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | |
| 22a. I certify that (I) (this hospital) attended the deceased from March 4, 1980 to Jan 20, 1982 , that (I) (we) lost saw the deceased alive on Jan 19, 1982 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death. | | | | | |
| 22b. SIGNATURE
Olusegun O. Lawoyin M.D. | | | | 22c. DATE SIGNED
2/24/82 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
OLUSEGUN O. LAWOYIN | | | | 22e. ADDRESS
5101 Lanier Ave, Baltimore, MD 21215 | |
| 23a. BURIAL, CREMATION, REMOVAL
Buried | | 23b. DATE
2/22/82 | | 23c. NAME OF CEMETERY OR CREMATORY
Baltimore Cent. | |
| 23d. LOCATION
STREET CITY OR TOWN COUNTY STATE
Balt. Md. | | 24. FUNERAL DIRECTOR
NAME ADDRESS
Mr. Carroll 1712 W. North Ave | | | |
| 25a. DATE REC'D. BY REGISTRAR
MAR 5 1982 | | | | 25b. REGISTRAR'S SIGNATURE
Thane Jan Nisler | |

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 24 hours of death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of this.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH | | | | REG. NO. 8 2 0 3 1 6 0 | | | |
|---|--|--|--|---|--|---|--|
| 1. FOR STATE REGISTRAR | | | | 2a. DATE OF DEATH | | | |
| 1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST
Peggy V. Glascoe | | | | 2b. DATE OF DEATH MONTH DAY YEAR
2 22 82 | | | |
| 3. SEX Female | | | | 2c. HOUR 2:35 P.M. | | | |
| 4. RACE Black | | 5. DATE OF BIRTH MONTH DAY YEAR
12 14 25 | | 6. AGE (IN YEARS LAST BIRTHDAY) 56 YRS | | IF UNDER 1 YEAR MONTHS DAYS
IF UNDER 24 HRS. HOURS MIN. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
Baltimore, Md. | | 7b. CITIZEN OF WHAT COUNTRY?
U.S.A. | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
Baltimore City MD | |
| 10. CITY OR TOWN OF DEATH
Baltimore City | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF IN SUCH FACILITY, GIVE STREET ADDRESS)
Mercy Hospital | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)
Homemaker | | 12b. KIND OF BUSINESS OR INDUSTRY | |
| 13a. STATE Maryland | | 13b. COUNTY - | | 13c. CITY OR TOWN Baltimore City | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 14. FATHER'S NAME FIRST MIDDLE LAST
Louis Briscoe | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST
Violet Thompson | | 13e. STREET ADDRESS
3615 Springdale Ave., Baltimore, Md 21215 | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)
No | | 16b. SOCIAL SECURITY NO.
218-14-9855 | | 17. INFORMANT ADDRESS
Shirley Hayes 1862 E. Fayette St. | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) 7991 Respiratory Arrest
DUE TO, OR AS A CONSEQUENCE OF (b)
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.
DUE TO, OR AS A CONSEQUENCE OF (c) | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
1/2 hr | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NO! WHILE AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 2/19 82 to 2/22 82, that (I) (we) last saw the deceased alive on 2/22 82, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | |
| 22b. SIGNATURE
Neal M. Friedlander, MD | | | | DEGREE
ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input checked="" type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | 22c. DATE SIGNED
2/22/82 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
Neal M. Friedlander, MD | | | | 22e. ADDRESS
301 St. Paul St. Baltimore, Md 21202 | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)
Burial | | 23b. DATE
2/27/82 | | 23c. NAME OF CEMETERY OR CREMATORY
Arbutus Mem. Pk. | | 23d. LOCATION
Baltimore Co. MD. | |
| 24. FUNERAL DIRECTOR NAME
Wm. C. March F/H 1101 E. North Ave. | | | | 25a. DATE REC'D BY REGISTRAR
FEB 23 1982 | | | |
| | | | | 25b. REGISTRAR'S SIGNATURE
Charles J. Walker | | | |

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 2 0 3 7 6 1

FOR
STATE
REGISTRAR

REG. NO.

| | | | | |
|--|--|--|---|--|
| 1. DECEASED NAME
(TYPE OR PRINT)
FIRST TILLIE MIDDLE FILLEY LAST GLASER GLASSER | | 2a. DATE OF DEATH
MONTH 2 DAY 11 YEAR 82 | | 2b. HOUR
6 45 A M |
| 3. SEX
FEMALE | 4. RACE
CAUCASIAN | 5. DATE OF BIRTH
MONTH 2 DAY 26 YEAR 1909 | | 6. AGE (IN YEARS LAST BIRTHDAY)
73 85 YRS. |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
MARYLAND | 7b. CITIZEN OF WHAT COUNTRY?
USA | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
BALTIMORE CITY MD. |
| 10. CITY OR TOWN OF DEATH
BALTIMORE | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
SINAI HOSPITAL | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
SALES LADY | 12b. KIND OF BUSINESS OR INDUSTRY
A.S. BECK SHOES |
| 13a. STATE
MD | | 13b. CITY OR TOWN
BALT. | 13c. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 14. FATHER'S NAME
FIRST SAMUEL MIDDLE STARK LAST STARK | | 15. MOTHER'S MAIDEN NAME
FIRST BESSIE MIDDLE BLUM LAST BLUM | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
NO | | 16b. SOCIAL SECURITY NO.
217-14-6241 | | 17. INFORMANT
MRS. JOAN HORNSTEIN 2030 OCEAN DR., APT. 2114 HALLANDALE, FL 33009 |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) MASSIVE G.I. BLEEDING
5789
DUE TO, OR AS A CONSEQUENCE OF
(b) ETIOLOGY UNCERTAIN
DUE TO, OR AS A CONSEQUENCE OF
(c) _____ | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)
HEPATITIS - NON A, NON B | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) |
| 21d. INJURY OCCURRED
WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE |
| 22a. I certify that (1) (this hospital) attended the deceased from 2-10 19 82 to 2-11 19 82 , that (1) (we) last saw the deceased alive on 2-11 19 82 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (1) (we) (did) (did not) view the body after death. | | | | |
| 22b. SIGNATURE
M. Ordoqui | | DEGREE
MD | | 22c. DATE SIGNED
2-11-82 |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
M. ORDOQUI M.D. | | 22e. ADDRESS
SINAI HOSPITAL, BALTO. MD. | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)
BURIAL | | 23b. DATE
FEB. 14, 1982 | 23c. NAME OF CEMETERY OR CREMATORY
BETH EL MEM. PARK | |
| 23d. LOCATION
CITY OR TOWN
RANDALLSTOWN | | COUNTY
BALTO. STATE
MD | | |
| 24. FUNERAL DIRECTOR
NAME
SOL LEVINSON & BROS., INC.
ADDRESS
6010 REISTERSTOWN RD. BALTO., MD 21215 | | 25a. DATE REC'D. BY REGISTRAR
FEB 17 1982 | | |
| 25b. REGISTRAR'S SIGNATURE
<i>James J. Nathan</i> | | | | |

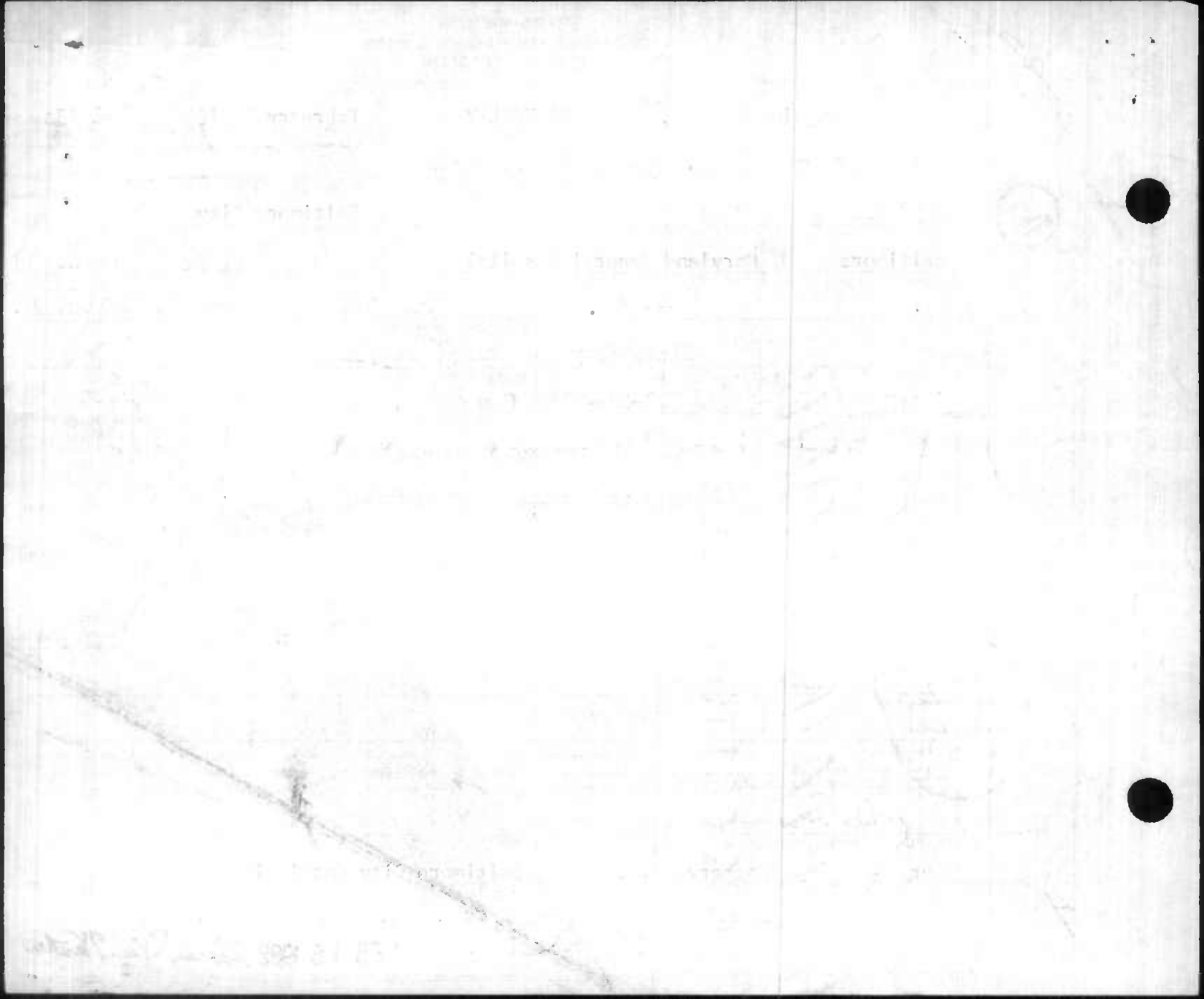
FEB 1 1961

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the health officer after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 2 0 3 / 6 2

| | | | |
|--|--|---|--|
| 1. FOR STATE REGISTRAR | | REG. NO. | |
| 1 DECEASED NAME (TYPE OR PRINT)
FIRST MIDDLE LAST
Hughie E. GLOTFELTY | | 2a DATE OF DEATH MONTH DAY YEAR
February 9, 1982 | |
| 3 SEX
Male c | | 2b HOUR
8:13a M | |
| 4 RACE
Cauc. | | 6 AGE (IN YEARS LAST BIRTHDAY)
57 YRS | |
| 5. DATE OF BIRTH MONTH DAY YEAR
Dec. 24, 1924 | | IF UNDER 1 YEAR
MONTHS DAYS HOURS MIN. | |
| 7a BIRTHPLACE (STATE OR FOREIGN COUNTRY)
Maryland | | 7b CITIZEN OF WHAT COUNTRY?
USA | |
| 8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9 BALTIMORE CITY OR COUNTY OF DEATH
Baltimore City MD. | |
| 10. CITY OR TOWN OF DEATH
Baltimore | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
Maryland General Hospital | |
| 12a USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)
Md. Baltimore, Balto. | | 12b KIND OF BUSINESS OR INDUSTRY
Sheet Metal Worker (Const) | |
| 13a STATE
Md. | | 13b CITY OR TOWN
Balto. | |
| 13c INSIDE CITY LIMITS?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 13d STREET ADDRESS
10000 Lodge Rd, Balto, MD. | |
| 14 FATHER'S NAME FIRST MIDDLE LAST
Levi Glotfelty | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST
Annie Steiding | |
| 16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)
Yes | | 16b SOCIAL SECURITY NO.
220-26-2054 | |
| 17 INFORMANT
same address | | 17 ADDRESS
same address | |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART 1. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>Probable Myocardial Infarction</u>
DUE TO, OR AS A CONSEQUENCE OF
(b) <u>Arteriosclerotic Heart Disease</u>
DUE TO, OR AS A CONSEQUENCE OF
(c) <u>Diabetes Mellitus</u> | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a) | | | |
| 19a DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | |
| 20a AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | |
| 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | 21d. LOCATION
STREET CITY OR TOWN COUNTY STATE | |
| 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | |
| 22a. I certify that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) lost
saw the deceased alive on _____, 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated
above, (I) (we) (did) (did not) view the body after death. | | | |
| 22b SIGNATURE
J. B. Zachary | | 22c. DATE SIGNED | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
Dr. James B. Zachary, M.D. | | 22e ADDRESS
Baltimore City Hospitals | |
| 23a BURIAL, CREMATION, REMOVAL (SPECIFY)
Burial | | 23b. DATE
Feb. 13, 1982 | |
| 23c NAME OF CEMETERY OR CREMATORY
Solomons Ch. Cem. | | 23d LOCATION
Quicksburg, VA. | |
| 24. FUNERAL DIRECTOR
Schlunneke Funeral Home, 9705 Belair Road
Baltimore, Maryland 21236 | | 25a. DATE REC'D BY REGISTRAR
FEB 16 1982 | |
| 25b. REGISTRAR'S SIGNATURE
Frances Jan Werthen | | | |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified by phone.

1 - FOR
STATE
REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 2 0 3 1 6 3

REG. NO.

| | | | | | | | |
|---|--|---|---|--|----------------------------|--|--|
| 1. DECEASED NAME
(TYPE OR PRINT)
FIRST MIDDLE LAST
EDWARD W.ayne GLOVER SR. | | | 2a. DATE OF DEATH
MONTH DAY YEAR
2 15 82 | | 2b. HOUR
11:30AM | | |
| 3 SEX
Male | | 4 RACE
White | | 5 DATE OF BIRTH
MONTH DAY YEAR
2 - 26 - 1916 | | 6. AGE (IN YEARS LAST BIRTHDAY)
YRS. MONTHS DAYS
65 | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
North Carolina | | 7b. CITIZEN OF WHAT COUNTRY?
U.S. A. | | 8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
BALTIMORE CITY MD. | |
| 10. CITY OR TOWN OF DEATH
Balto. CITY | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
THE UNION MEMORIAL HOSPITAL | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
Manager | | 12b. KIND OF BUSINESS OR INDUSTRY
Retail Chain | |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) | | | | | | | |
| 13a. STATE
Maryland | | 13b. COUNTY
--- | | 13c. CITY OR TOWN
Baltimore | | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 14 FATHER'S NAME
FIRST MIDDLE LAST
Army M. Glover | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
Nevada Hudson | | 13e. STREET ADDRESS
2819 Overland Ave. 21214 | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)
No | | 16b. SOCIAL SECURITY NO.
241.16.0254 | | 17. INFORMANT
ADDRESS
Loretta V. Glover Same as 13e. | | | |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART 1. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Extensive Laryngeal Ca
DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b) _____
DUE TO, OR AS A CONSEQUENCE OF
(c) _____
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
-1844 | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a) _____ | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | |
| 21d. INJURY OCCURRED
WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 2/15 19 82 to 2/15 19 82 , that (I) (we) last saw the deceased alive on 2/15 19 82 , and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death. | | | | | | | |
| 22b. SIGNATURE
David C. Allen MD | | | | DEGREE
MD | | 22c. DATE SIGNED
2/15/82 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
DAVID C. ALLEN MD. | | | | 22e. ADDRESS
201 UNIVERSITY PARKWAY | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)
Cremation | | 23b. DATE
2/16/1982 | | 23c. NAME OF CEMETERY OR CREMATORY
Green Mount | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
Balto. Md. | |
| 24 FUNERAL DIRECTOR
NAME
Walter Brooks Bradley Inc. Dundalk, Md. 21222 | | | | 25a. DATE OF RECORD BY REGISTRAR
FEB 17 1982 | | | |

THE STATE OF NEW YORK

IN SENATE

JANUARY 1, 1907

REPORT OF THE

COMMISSIONERS OF THE LAND OFFICE

FOR THE YEAR 1906

ALBANY: J.B. LIPPINCOTT & CO., PRINTERS, 1907.

THE STATE OF NEW YORK

IN SENATE

JANUARY 1, 1907

REPORT OF THE

COMMISSIONERS OF THE LAND OFFICE

FOR THE YEAR 1906

ALBANY: J.B. LIPPINCOTT & CO., PRINTERS, 1907.

THE STATE OF NEW YORK

IN SENATE

JANUARY 1, 1907

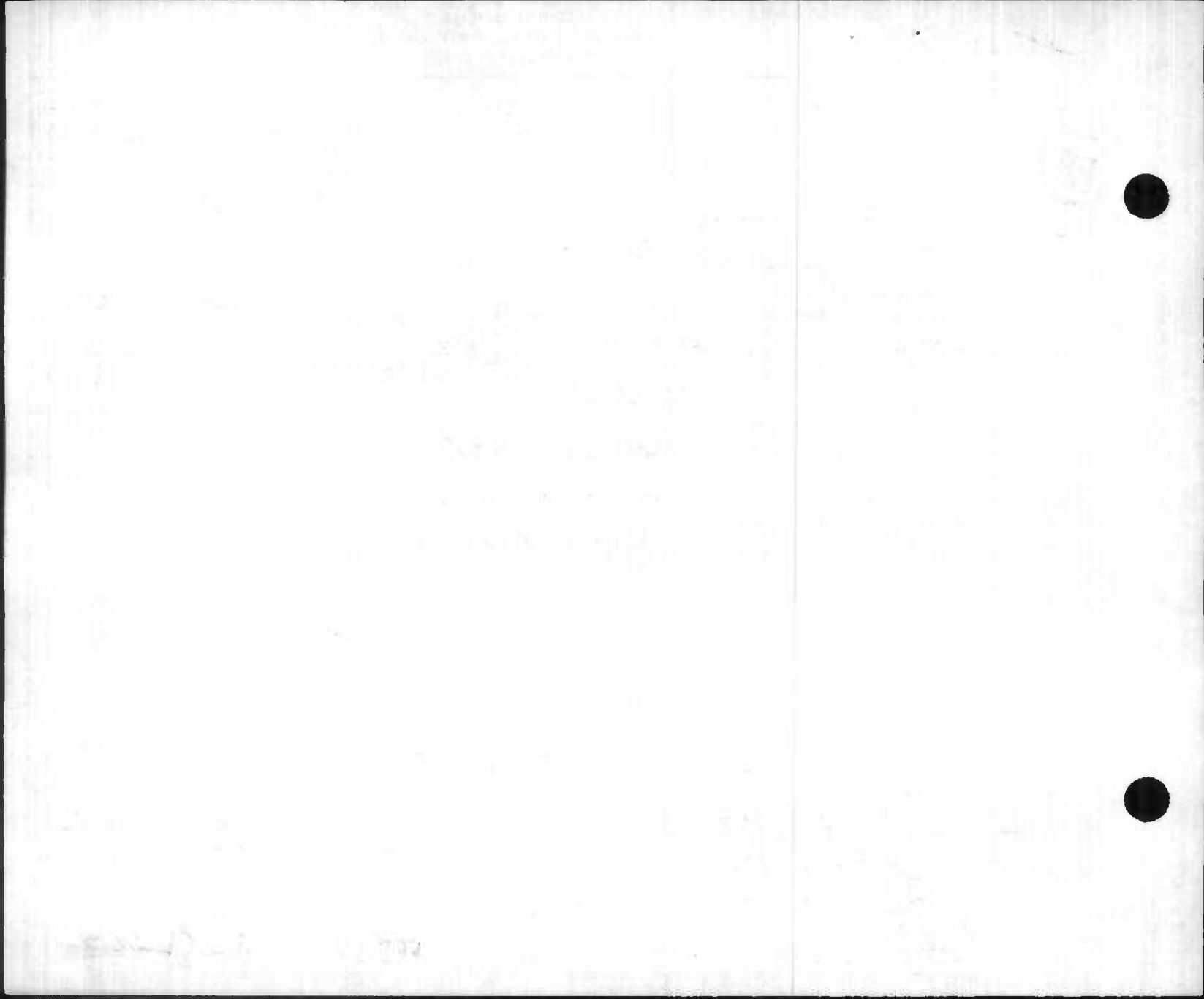
REPORT OF THE

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours of death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH | | | | 8 2 0 3 / 6 4 | | | |
|---|--|---|--|--|--|---|--|
| 1. FOR STATE REGISTRAR | | | | REG. NO. | | | |
| 1 DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST
RICHARD G. GOLDRING | | | | 2a DATE OF DEATH MONTH DAY YEAR
2 16 82 | | 2b HOUR
1:20AM | |
| 3 SEX
MALE | | 4 RACE
BLACK | | 5 DATE OF BIRTH MONTH DAY YEAR
3 31 16 | | 6 AGE (IN YEARS (LAST BIRTHDAY))
65 YRS. | |
| 7a BIRTHPLACE (STATE OR FOREIGN COUNTRY)
NEW YORK | | 7b CITIZEN OF WHAT COUNTRY?
U.S.A. | | 8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9 BALTIMORE CITY OR COUNTY OF DEATH
BALTIMORE, CITY MD. | |
| 10 CITY OR TOWN OF DEATH
BALTIMORE | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
VAMC, 3900 LOCH RAVEN BLVD. | | 12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | | 12b KIND OF BUSINESS OR INDUSTRY | |
| 13a USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)
13a STATE MARYLAND 13b COUNTY 13c CITY OR TOWN BALTIMORE 13d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | | 13e STREET ADDRESS
5037 Queensberry Ave 21215 | | | |
| 14 FATHER'S NAME FIRST MIDDLE LAST
GARFIELD R. GOLDRING | | | | 15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST
MARIE BALLARD | | | |
| 16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)
YES | | 16b SOCIAL SECURITY NO.
215 14 0542 | | 17 INFORMANT Viola V. Goldring 5037 Queensberry Ave
VAMC, LOCH RAVEN MEDICAL RECORDS | | | |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>Cardiac arrest</u>
DUE TO, OR AS A CONSEQUENCE OF (b) <u>Candida Sepsis</u>
DUE TO, OR AS A CONSEQUENCE OF (c) <u>Aspiration Pneumonia</u>
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | | | | | | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: 10 | | | | | | | |
| 19a DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | |
| 21d INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK | | 21e PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f LOCATION STREET CITY OR TOWN COUNTY STATE | | | |
| 22a I certify that * (this hospital) attended the deceased from <u>1-31</u> 19 <u>82</u> to <u>2-16</u> 19 <u>82</u> , that * (we) lost <u>above</u> the deceased alive on <u>2-16</u> 19 <u>82</u> , and that in <u>xxx</u> (our) opinion death occurred on the date and hour and from the causes stated above, * (we) (did) <u>xxx</u> view the body after death. | | | | | | | |
| 22b SIGNATURE
A. Foong MD | | | | DEGREE
ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> | | 22c DATE SIGNED
2/16/82 | |
| 22d PHYSICIAN'S NAME (TYPE OR PRINT)
A Foong MD | | | | 22e ADDRESS
3900 LOCH RAVEN BLVD. BALTIMORE, MD. 21218 | | | |
| 23a BURIAL, CREMATION, REMOVAL (SPECIFY)
Burial | | 23b DATE
2/19/82 | | 23c NAME OF CEMETERY OR CREMATORY
Baltimore Cemetery | | 23d LOCATION CITY OR TOWN COUNTY STATE
Baltimore Md | |
| 24 FUNERAL DIRECTOR
William C. March F/H 1101 E. North Avenue | | | | 25a DATE REC'D BY REGISTRAR
FEB 17 1982 | | | |



TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, Page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 2 0 3 / 6 5

| 1. DECEASED NAME
(TYPE OR PRINT) | | | | 2a. DATE OF DEATH | | | | 2b. HOUR | | | |
|---|--|-----------|--|---|--|----------------------------------|--|--|--|--------------------|--|
| ETHEL W. GOLDSTEIN | | | | Feb 17 82 | | | | 6 40P M | | | |
| 3. SEX | | 4. RACE | | 5. DATE OF BIRTH | | 6. AGE (IN YEARS, LAST BIRTHDAY) | | 7. IF UNDER 1 YEAR | | 7. IF UNDER 24 HRS | |
| FEMALE | | CAUCASIAN | | 8-1-88 | | 87 | | MONTHS | | DAYS | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) | | | | 7b. CITIZEN OF WHAT COUNTRY? | | | | 9. BALTIMORE CITY OR COUNTY OF DEATH | | | |
| MARYLAND | | | | USA | | | | BALTIMORE CITY MD. | | | |
| 10. CITY OR TOWN OF DEATH | | | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION | | | | 12a. USUAL OCCUPATION | | | |
| BALTIMORE | | | | SINAI HOSPITAL | | | | HOUSEWIFE | | | |
| 13a. STATE | | | | 13b. COUNTY | | | | 13c. CITY OR TOWN | | | |
| MARYLAND | | | | BALTO. | | | | BALTIMORE | | | |
| 14. FATHER'S NAME | | | | 15. MOTHER'S MAIDEN NAME | | | | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? | | | |
| ABRAHAM | | | | FANNIE | | | | NO | | | |
| 16b. SOCIAL SECURITY NO. | | | | 17. INFORMANT | | | | 18. CAUSE OF DEATH | | | |
| 216-52-7656 | | | | GUSTAV GOLDSTEIN | | | | PART 1. DEATH WAS CAUSED BY | | | |
| 130 SLADE AVE., APT. 525 BALTO., MD 21208 | | | | ACUTE MYOCARDIAL INFARCTION | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | | |
| 4100 | | | | DUE TO, OR AS A CONSEQUENCE OF | | | | 20 minute | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 | | | | CHRONIC OBSTRUCTIVE AIRWAY DISEASE | | | | | | | |
| 19a. DATE OF OPERATION | | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY? | | | |
| | | | | | | | | YES <input type="checkbox"/> NO <input type="checkbox"/> | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH | | | | 21b. TIME OF INJURY | | | | 21c. HOW INJURY OCCURRED | | | |
| (IF EITHER NOTIFY MEDICAL EXAMINER) | | | | HOUR A.M. MONTH DAY YEAR | | | | (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | |
| 21d. INJURY OCCURRED | | | | 21e. PLACE OF INJURY | | | | 21f. LOCATION | | | |
| WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | | | (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | | | STREET CITY OR TOWN COUNTY STATE | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from | | | | 2/15/82 | | | | to 2/17/82 | | | |
| saw the deceased alive on | | | | 2/17/82 | | | | and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | |
| 22b. SIGNATURE | | | | DEGREE | | | | 22c. DATE SIGNED | | | |
| W. ANIN, M.D. | | | | MD | | | | 2/17/82 | | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) | | | | 22e. ADDRESS | | | | | | | |
| W. ANIN, M.D. | | | | SINAI HOSP. - BALTO., MD | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) | | | | 23b. DATE | | | | 23c. NAME OF CEMETERY OR CREMATORY | | | |
| BURIAL | | | | FEB. 19, 1982 | | | | BALTIMORE HEBREW | | | |
| 24. FUNERAL DIRECTOR | | | | 25a. DATE REC'D. BY REGISTRAR | | | | 25b. REGISTRAR'S SIGNATURE | | | |
| SOL LEVINSON & BROS., INC. | | | | FEB 24 1982 | | | | [Signature] | | | |
| 6010 REISTERSTOWN RD. BALTO., MD 21215 | | | | | | | | | | | |

1881

1881

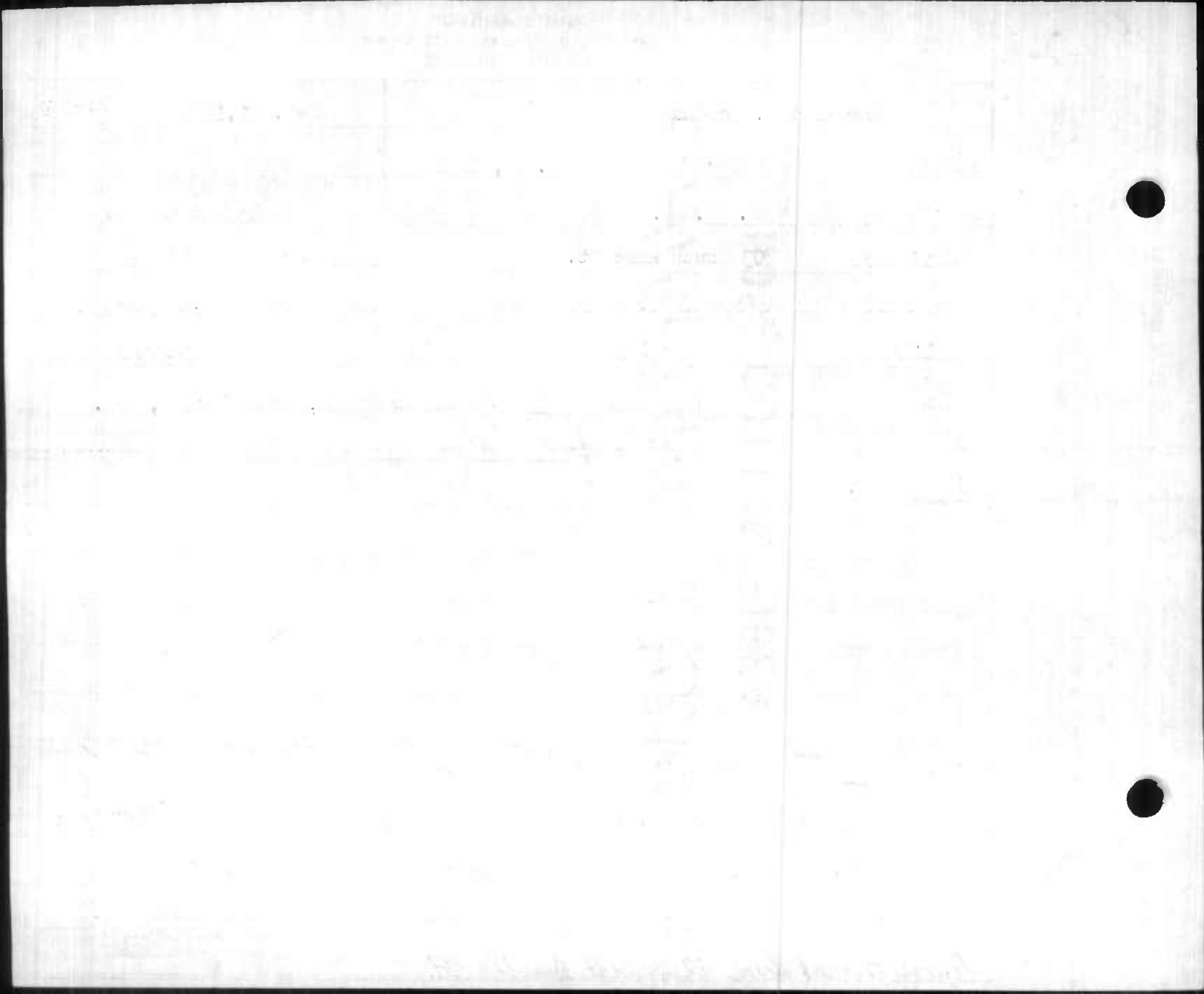
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

| STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH | | | | REG. NO. 8203166 | | | |
|---|--|--|--|---|--|--|--|
| 1. FOR STATE REGISTRAR | | | | 2a. DATE OF DEATH MONTH DAY YEAR | | | |
| 1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST
Margaret R. Goodman | | | | Feb. 21, 1982 | | | |
| 3. SEX
Female | | 4. RACE
Caucasian | | 5. DATE OF BIRTH MONTH DAY YEAR
Feb. 5, 1922 | | 2b. HOUR
2:45 p.m. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
Maryland | | 7b. CITIZEN OF WHAT COUNTRY?
U. S. A. | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 6. AGE (IN YEARS LAST BIRTHDAY) YRS. MONTHS DAYS
60 | |
| 10. CITY OR TOWN OF DEATH
Baltimore | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
803 South Rose St. | | 9. BALTIMORE CITY OR COUNTY OF DEATH
Baltimore City MD. | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)
Housewife | |
| 13a. STATE
Maryland | | 13b. COUNTY
Baltimore | | 13c. CITY OR TOWN
Baltimore | | 12b. KIND OF BUSINESS OR INDUSTRY
Home | |
| 14. FATHER'S NAME FIRST MIDDLE LAST
Alfred Burgan | | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST
Bessie Stover | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)
No | | 16b. SOCIAL SECURITY NO.
213124034 | | 17. INFORMANT ADDRESS
Michael Goodman, Baltimore, Md. | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>Metastatic colon cancer</u>
1539
DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b) _____
DUE TO, OR AS A CONSEQUENCE OF
(c) _____
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
5 yrs. | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | |
| 22a. I certify that (I) (the hospital) attended the deceased from <u>Sept. 19 78</u> , to <u>Feb. 22, 19 82</u> , that (I) (we) last saw the deceased alive on <u>Feb. 11, 19 82</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did not) view the body after death. | | | | | | | |
| 22b. SIGNATURE
Paul Chang, MD | | | | DEGREE
ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | 22c. DATE SIGNED
2/22/82 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
Paul Chang, MD | | | | 22e. ADDRESS
Good Samaritan Hospital | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)
Burial | | 23b. DATE
2/23/82 | | 23c. NAME OF CEMETERY OR CREMATORY
Denton Cemetery | | 23d. LOCATION CITY OR TOWN COUNTY STATE
Denton Caroline MD | |
| 24. FUNERAL DIRECTOR NAME
Moore Funeral Home | | | | 25. DATE REC'D. BY REGISTRAR
MAR 1 1982 | | | |
| ADDRESS
12 So 2nd St. Denton, MD | | | | 25b. REGISTRAR SIGNATURE
[Signature] | | | |



STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 2 0 3 / 6 1

1. FOR
STATE
REGISTRAR

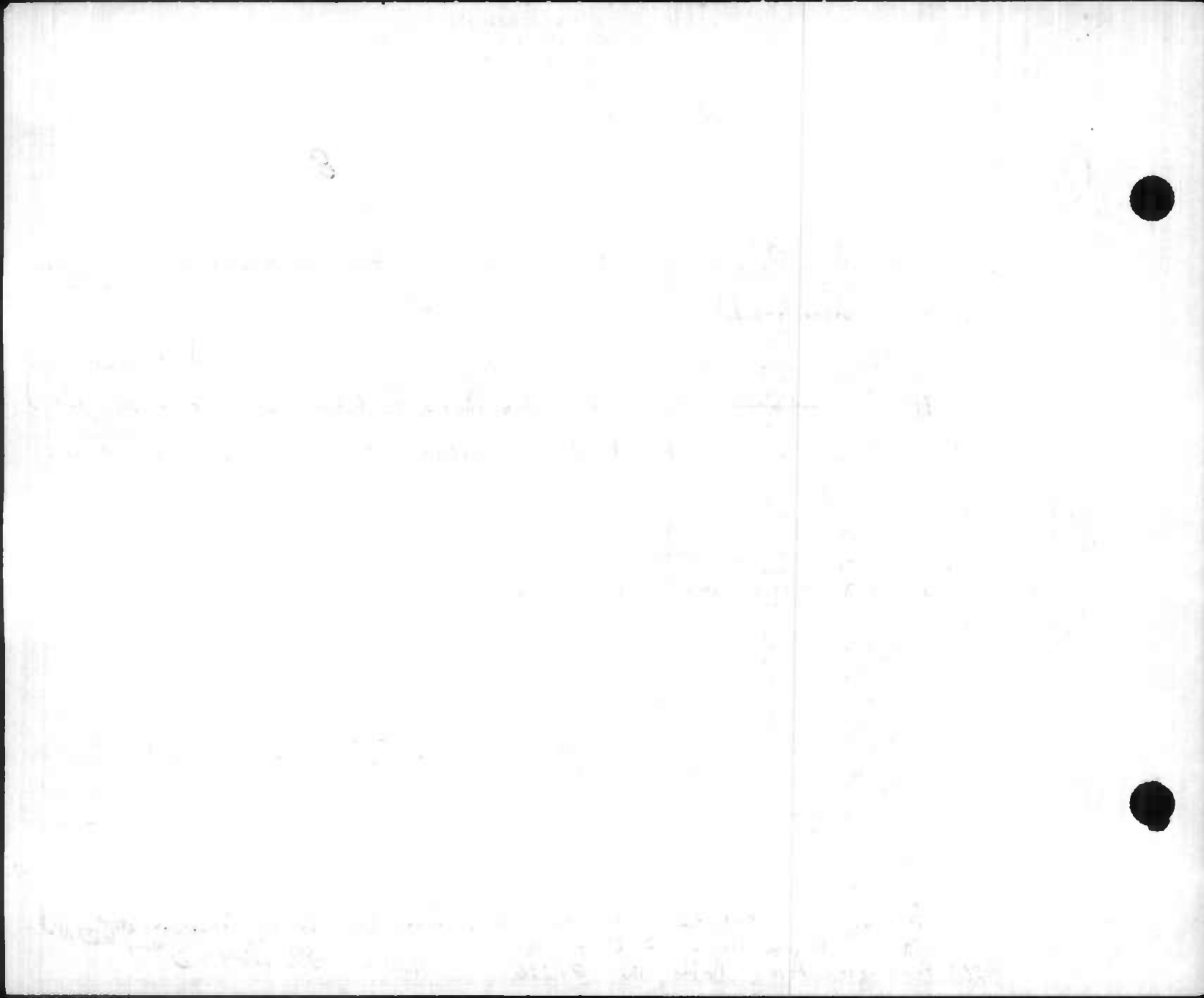
REG. NO.

| | | | | | | | |
|--|--|---|--|---|--|--|--|
| 1. DECEASED NAME
(TYPE OR PRINT) Joseph W. GORMAN | | | | 2a. DATE OF DEATH
MONTH DAY YEAR
2-24-82 | | 2b. HOUR
MIN.
7:30 P.M. | |
| 3. SEX
Male | | 4. RACE
White | | 5. DATE OF BIRTH
MONTH DAY YEAR
6 03 1903 | | 6. AGE (IN YEARS LAST BIRTHDAY)
YRS.
78 | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
Maryland | | 7b. CITIZEN OF WHAT COUNTRY?
U.S.A. | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
Baltimore City MD | |
| 10. CITY OR TOWN OF DEATH
Baltimore | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
Federal Hill Nursing Home | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
Foreman - Road Construction | | 12b. KIND OF BUSINESS OR INDUSTRY
21061 | |
| 13a. STATE
MD | | 13b. COUNTY
Anne Arundel | | 13c. CITY OR TOWN
Green Burnie | | 13d. INSIDE CITY LIMITS?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
Curtis Gorman | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
Magnolia Unknown | | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
NO | | | |
| 16b. SOCIAL SECURITY NO.
215-07-2016 | | 17. INFORMANT
ADDRESS
Mrs. Marie E. Kitzmiller (Same as 13c.) | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART 1. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Metastatic carcinoma of lung
1629
DUE TO, OR AS A CONSEQUENCE OF (b) _____
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. }
DUE TO, OR AS A CONSEQUENCE OF (c) _____
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
6 weeks | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)
ASCVD, CHF, Arterial, COPD | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | |
| 21d. INJURY OCCURRED
WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 9-2- 19 81 to 2-24- 19 82 , that (I) (we) lost
saw the deceased alive on 2-24- 19 82 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated
above, (I) (we) (did) (did not) view the body after death. | | | | | | | |
| 22b. SIGNATURE
Shaukat Y. Khan MD | | DEGREE | | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | 22c. DATE SIGNED
2-24-82 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
SHAUKAT Y. KHAN | | | | 22e. ADDRESS
1528 King William Drive, Balti, MD | | | |
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)
Burial | | 23b. DATE
3-1-82 | | 23c. NAME OF CEMETERY OR CREMATORY
Green Haven Mem. Park | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
Green Burnie Anne Arundel | |
| 24. FUNERAL DIRECTOR
NAME
McCall's Funeral Home of Curtis Bay
ADDRESS
4260 Pennington Ave. Balti, N. 21226 | | | | 25a. DATE REC'D. BY REGISTRAR
MAR 2 1982 | | | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the death certificate with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner will be notified.

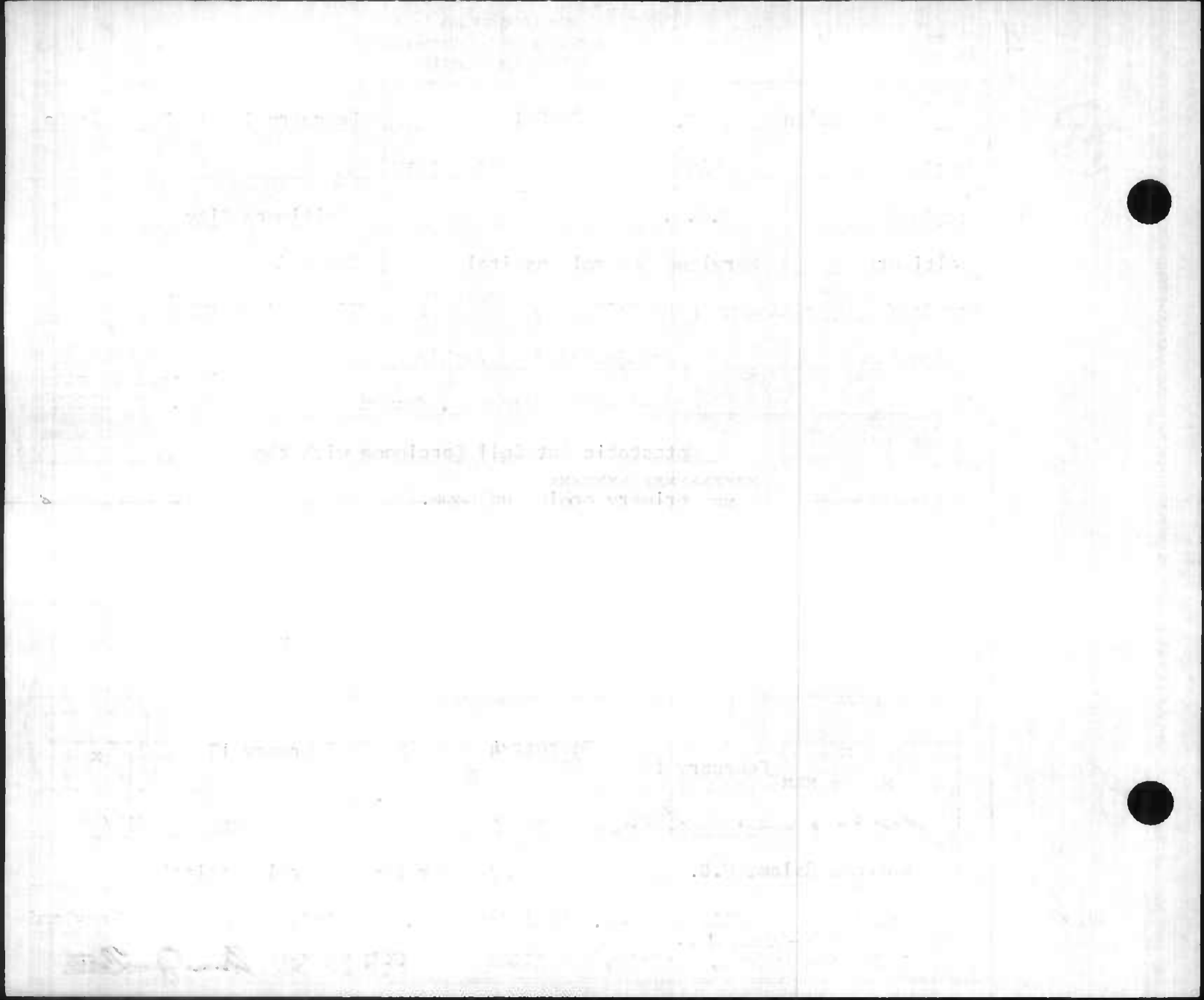


TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 of 2.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH | | | | | | | | | | 8 2 0 3 / 6 8 | |
|--|--|--|--|---|--|---|--|--|---------------------|--|--|
| 1. FOR STATE REGISTRAR | | REG. NO. | | | | | | | | | |
| 1. DECEASED NAME (TYPE OR PRINT)
FIRST MIDDLE LAST
Helen G. GORSKI | | | | | | 2a. DATE OF DEATH
MONTH DAY YEAR
February 10, 1982 | | | 2b. HOUR
7:00a M | | |
| 3. SEX
Female | | 4. RACE
White | | 5. DATE OF BIRTH
MONTH DAY YEAR
8 29 1917 | | 6. AGE (IN YEARS (LAST BIRTHDAY))
64 YRS | | IF UNDER 1 YEAR
MONTHS DAYS | | IF UNDER 24 HRS
HOURS MIN. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
Maryland | | 7b. CITIZEN OF WHAT COUNTRY?
U.S.A. | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
Baltimore City MD. | | | | | |
| 10. CITY OR TOWN OF DEATH
Baltimore | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
Maryland General Hospital | | | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
Housewife | | 12b. KIND OF BUSINESS OR INDUSTRY | | | |
| 13a. STATE
Maryland | | 13b. COUNTY
Baltimore | | 13c. CITY OR TOWN
Dundalk | | 13d. INSIDE CITY LIMITS?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 13e. STREET ADDRESS
527 Bayside Drive | | | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
Stephen Kazmierski | | | | | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
Sophia Zuhowski | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
No | | 16b. SOCIAL SECURITY NO.
(IF YES, GIVE WAR OR DATES)
214-18-5509 | | 17. INFORMANT
James A. Gorski | | | | ADDRESS 527 Bayside Drive
Balto. MD 21222 | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART 1. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Metastatic Oat Cell Carcinoma with the
1629 XXXXXXXXXXXXXXXXXXXX
xx primary origin, unknown.
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.
DUE TO, OR AS A CONSEQUENCE OF
(c) | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | | | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/> | | | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | | | |
| 22a. I certify that (X) (this hospital) attended the deceased from February 4, 19 82, to February 10, 19 82, that (X) (we) lost the deceased above, (X) (we) (did) (did not) view the body after death, and that in (m) (our) opinion death occurred on the date and hour and from the causes stated | | | | | | | | | | | |
| 22b. SIGNATURE
Mohammad Aslam, M.D. | | | | | | DEGREE
M.D. | | ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> | | 22c. DATE SIGNED
2/10/82 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
Mohammad Aslam, M.D. | | | | | | 22e. ADDRESS
c/o Maryland General Hospital | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)
Burial | | 23b. DATE
2/13/82 | | 23c. NAME OF CEMETERY OR CREMATORY
St. Stanislaus Cem. | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
Baltimore Maryland | | | | | |
| 24. FUNERAL DIRECTOR
NAME Duda-Ruck, Inc.
ADDRESS 7922 Wise Avenue, Dundalk, MD 21222 | | | | | | 25a. DATE REC'D. BY REGISTRAR
FEB 16 1982 | | 25b. REGISTRAR'S SIGNATURE
Thomas J. [Signature] | | | |



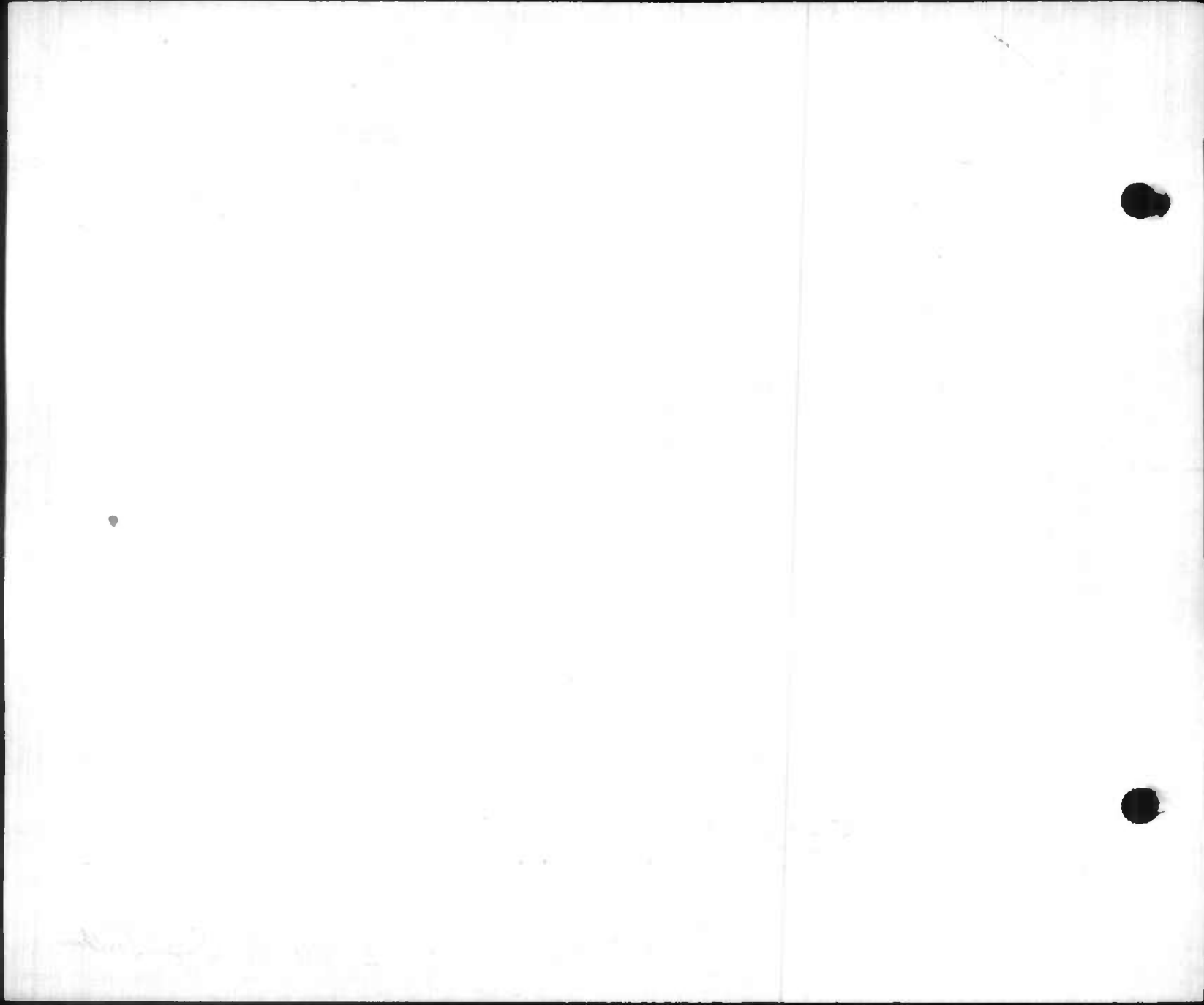
TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE ADVISE THE MEDICAL EXAMINER. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. GIVE PAGES 4 AND 5 TO THE FUNERAL DIRECTOR. GIVE PAGE 6 TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM-3. RETAIN PAGE 5 FOR YOUR FILE.

TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PLESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

REG. NO.

DHMH - 17
(VR A15 ME (5))
15M 2/80

263.



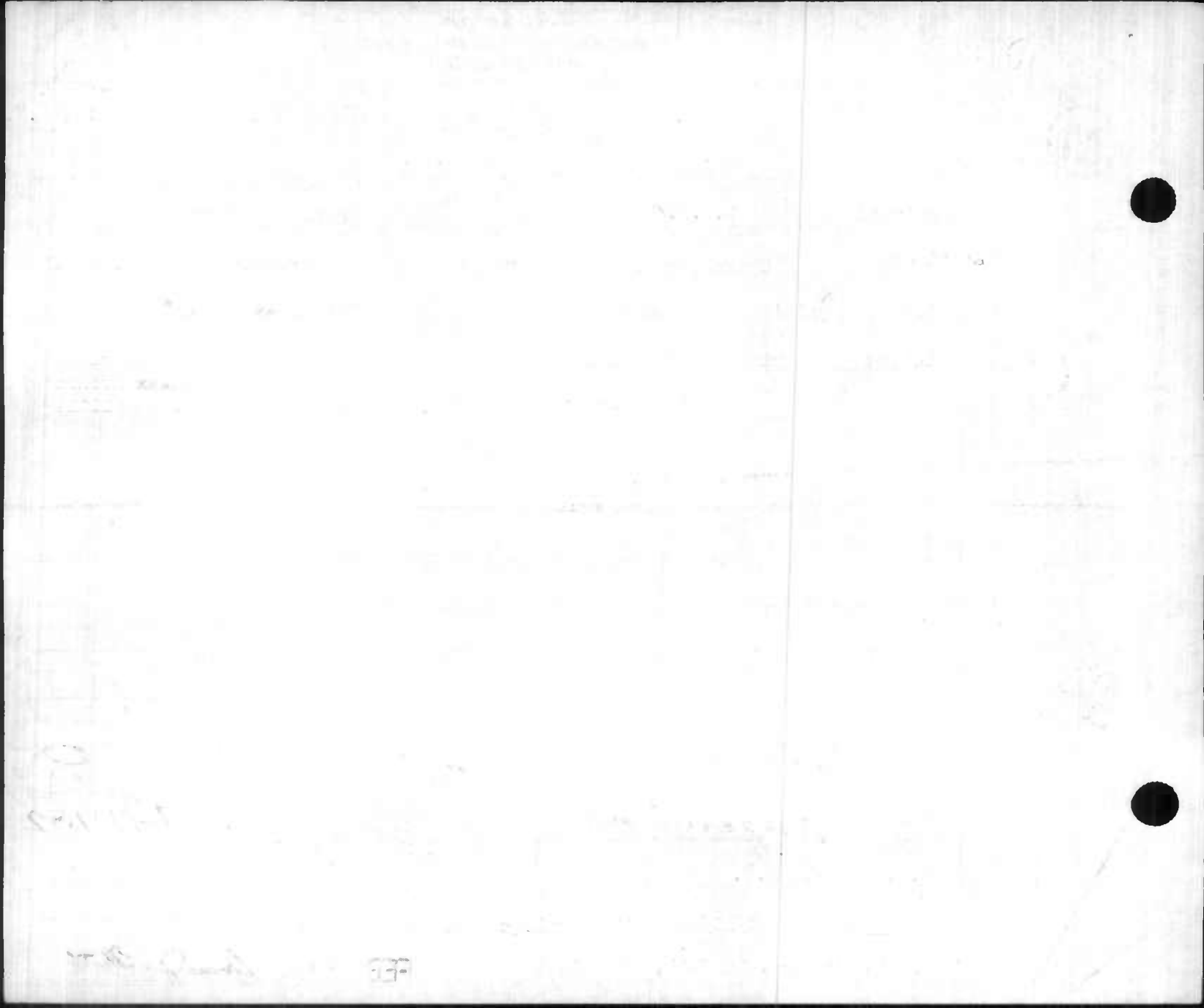
STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 2 0 3 7 7 0

1 - FOR
STATE
REGISTRAR

REG. NO.

| | | | | | |
|---|--|---|---|---|--|
| 1. DECEASED NAME
(TYPE OR PRINT)
WALTER A. GRAFFIUS | | | 2a. DATE OF DEATH
MONTH DAY YEAR
FEBRUARY 11, 1982 | | 2b. HOUR
2:45 P.M. |
| 3. SEX
Male | 4. RACE
White | 5. DATE OF BIRTH
MONTH DAY YEAR
3 7 1907 | | 6. AGE (IN YEARS LAST BIRTHDAY)
74 YRS. | IF UNDER 1 YEAR
MONTHS DAYS
IF UNDER 24 HRS.
HOURS MIN. |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
Pennsylvania | 7b. CITIZEN OF WHAT COUNTRY?
U.S.A. | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
Baltimore City MD | |
| 10. CITY OR TOWN OF DEATH
Baltimore | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
Church Hospital Corporation | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
Electrician | 12b. KIND OF BUSINESS OR INDUSTRY
Beth. Steel | |
| 13a. STATE
Maryland | | 13b. COUNTY
Baltimore | 13c. CITY OR TOWN
Essex | 13d. INSIDE CITY LIMITS?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | 13e. STREET ADDRESS
728 Essex Avenue |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
Richard Irvin Graffius | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
Fanny M. Wolfren | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
No | | 16b. SOCIAL SECURITY NO.
(IF YES, GIVE WAR OR DATES)
178-10-7081 | 17. INFORMANT
Ronald K. Graffius | | ADDRESS
728 Essex Avenue
Balto. MD 21221 |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART 1. DEATH WAS CAUSED BY:
5860 IMMEDIATE CAUSE (a) <u>RESPIRATORY FAILURE</u>
DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last
(b) <u>RENAL FAILURE</u>
DUE TO, OR AS A CONSEQUENCE OF
(c) _____ | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) _____ | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | |
| 21d. INJURY OCCURRED
WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | |
| 22a. I certify that (1) (this hospital) attended the deceased from <u>JANUARY 13, 1982</u> , to <u>FEBRUARY 11, 1982</u> , that (I) (we) last saw the deceased alive on <u>FEBRUARY 11, 1982</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | |
| 22b. SIGNATURE
<i>A. F. Nazemi M.D.</i> | | DEGREE
ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> | | 22c. DATE SIGNED
2/11/82 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
A.F. NAZEMI, M.D. | | 22e. ADDRESS
CHURCH HOSPITAL CORPORATION
100 NORTH BROADWAY, BALTIMORE, MD 21231 | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)
Burial | | 23b. DATE
2/15/82 | 23c. NAME OF CEMETERY OR CREMATORY
Meadowridge Mem. Park | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
Dorsey Howard Maryland |
| 24. FUNERAL DIRECTOR
NAME
Duda-Ruck, Inc.
7922 Wise Avenue, Dundalk, MD 21222 | | | 25a. DATE REC'D. BY REGISTRAR
FEB 16 1982 | | 25b. REGISTRAR'S SIGNATURE
<i>Thomas J. Huth</i> |



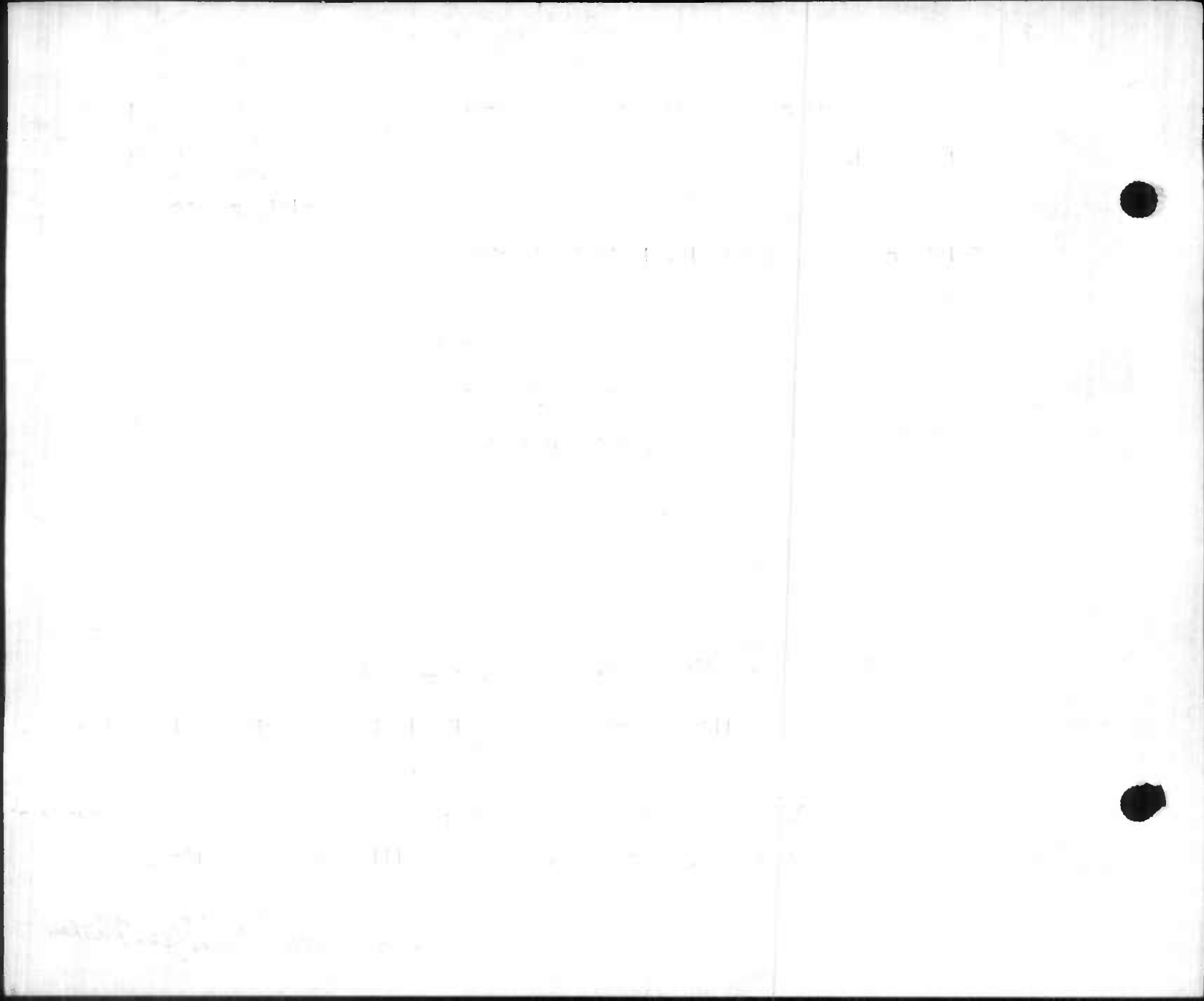
TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH. WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

1- FOR
STATE
REGISTRAR

| | | | | | | | | | | | | | | |
|--|--|--|---|--|--|--|--|--|---|--|--|--|--|--|
| 1. DECEASED NAME
(TYPE OR PRINT) | | | 2a. DATE KNOWN OF DEATH | | | 2b. DATE OF ESTIMATED DEATH | | | 2c. DATE PRONOUNCED DEAD | | | 2d. HOUR | | |
| Dexter Eugene Gray | | | 2. SEX
Male | | | 4. RACE
Black | | | 5. DATE OF BIRTH
12 23 54 | | | 6. AGE (IN YEARS)
27 | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
MD | | | 7b. CITIZEN OF WHAT COUNTRY?
USA | | | 8. MARRIED
WIDOWED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | | 9. BALTIMORE CITY OR COUNTY OF DEATH
Baltimore City, MD | | | 10. CITY OR TOWN OF DEATH
Baltimore | | |
| 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
2800 Blk. Indianhead Drive | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | | | 12b. KIND OF BUSINESS OR INDUSTRY | | | 13a. STATE
MD | | | 13b. COUNTY | | |
| 13c. CITY OR TOWN
Baltimore | | | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | 13e. STREET ADDRESS
813 Cator Avenue | | | 14. FATHER'S NAME
Levi White | | | 15. MOTHER'S MAIDEN NAME
Shirley Gray | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO, OR UNKNOWN)
No | | | 16b. SOCIAL SECURITY NO.
216-62-2876 | | | 17. INFORMANT
Shirley Gray | | | 17. ADDRESS
813 Cator Avenue | | | 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>Gunshot wound of head</u>
DUE TO, OR AS A CONSEQUENCE OF
(b) _____
DUE TO, OR AS A CONSEQUENCE OF
(c) _____ | | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a). | | | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | |
| 19a. DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | | | | | | 20. AUTOPSY?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | | | |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH | | | 21b. TIME OF INJURY
HOUR <u>7:40</u> P.M. MONTH <u>2</u> DAY <u>21</u> YEAR <u>82</u> | | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)
Subject shot | | | | | | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK | | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)
Clifton Park | | | 21f. LOCATION
CITY OR TOWN <u>Baltimore</u> COUNTY <u>Balto.</u> STATE <u>Md.</u> | | | | | | | | |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input checked="" type="checkbox"/> Undetermined manner <input type="checkbox"/> . | | | | | | | | | | | | | | |
| ACTUAL SIGNATURE
<i>H R Guard</i> | | | TITLE (SPECIFY)
Assistant | | | MEDICAL EXAMINER | | | DATE SIGNED
2/22/82 | | | | | |
| EXAMINER'S NAME
(TYPE OR PRINT)
Hormez R. Guard, M.D. | | | ADDRESS
111 Penn St. Balto., MD. | | | 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)
Burial | | | 23b. DATE
2/27/82 | | | | | |
| 23c. NAME OF CEMETERY OR CREMATORY
Baltimore Cemetery | | | 23d. LOCATION
CITY OR TOWN
Baltimore | | | 23e. DATE REC'D. BY REGISTRAR
FEB 23 1982 | | | 23f. REGISTRAR
<i>James J. Nathan</i> | | | | | |
| 24. FUNERAL DIRECTOR
NAME
Wm. C. March F/H | | | ADDRESS
1101 E. North Ave. | | | 25. DATE REC'D. BY REGISTRAR
FEB 23 1982 | | | 25f. REGISTRAR
<i>James J. Nathan</i> | | | | | |



TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

BP

DHMH - 16 50M 1/81
(VRA 15, 4)

| STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE | | | | | | | | | | 8 2 0 3 7 7 2 | |
|--|--|---|--|---|--|--|--|---|--|---------------|--|
| 1. FOR STATE REGISTRAR | | | | | | | | | | REG. NO. | |
| 1. DECEASED NAME
(TYPE OR PRINT) ROSEMARY E. GREEK | | | | | | 2a. DATE OF DEATH
MONTH DAY YEAR
2-5-82 | | 2b. HOUR
4:30 PM | | | |
| 3. SEX
FEMALE | | 4. RACE
WHITE | | 5. DATE OF BIRTH
MONTH DAY YEAR
11 22 1907 | | 6. AGE (IN YEARS LAST BIRTHDAY)
74 YRS. | | IF UNDER 1 YEAR
MONTHS DAYS HOURS MIN. | | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
VIRGINIA | | 7b. CITIZEN OF WHAT COUNTRY?
USA. | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
CITY MD | | | | | |
| 10. CITY OR TOWN OF DEATH
BALTIMORE | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
UNWOL Md. | | | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
Housewife | | 12b. KIND OF BUSINESS OR INDUSTRY | | | |
| 13a. STATE
MD | | 13b. COUNTY
Anne Arundel | | 13c. CITY OR TOWN
Glen Burnie | | 13d. INSIDE CITY LIMITS?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS
504 HANLEN ROAD | | | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
Thomas = Gorman | | | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
Margaret Cecelia Bahen | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
no | | 16b. SOCIAL SECURITY NO.
220-24-5967 | | 17. INFORMANT
Med Record | | | | ADDRESS | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c):
PART 1. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) CARDIO RESP ARREST
0396
DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last:
(b) INCREASED INTRACRANIAL PRESSURE 1 DAY
DUE TO, OR AS A CONSEQUENCE OF
(c) BRAIN TUMOR
1 month | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
1 HR | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:
HYPONATREMIA. ARRHYTHMIA | | | | | | | | | | | |
| 19a. DATE OF OPERATION
1-13-82 | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED
BRAIN TUMOR | | | | 20a. AUTOPSY?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | | | | | |
| 21d. INJURY OCCURRED
WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from JAN 5, 19 82 to FEB 5, 19 82 that (I) (we) lost saw the deceased alive on FEB 5, 19 82 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | | | |
| 22b. SIGNATURE
Daniel J. Won M.D. | | | | | | DEGREE
MD | | 22c. DATE SIGNED
2-5-82 | | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
DANIEL J. WON | | | | 22e. ADDRESS
22 S GREENE ST BALTO | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)
Burial | | 23b. DATE
2/9/82 | | 23c. NAME OF CEMETERY OR CREMATORY
Glen Haven Cem. | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
Glen Burnie, A.A. Md. | | | | | |
| 24. FUNERAL DIRECTOR
NAME
Raymond C. Fink | | | | ADDRESS
Glen Burnie, Md. | | 25a. DATE REC'D. BY REGISTRAR
FEB 8 1982 | | 25b. REGISTRAR'S SIGNATURE
James J. Nathan | | | |

MEDICAL CERTIFICATION

(1)

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the informant, it should be detached for use as the burial-transit permit. Then please remove carbon copies. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

1 - FOR
STATE
REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

8 2 0 3 7 7 3

| | | | | | | | |
|---|--|--|--|--|--|--|--|
| 1. DECEASED NAME
(TYPE OR PRINT)
FIRST MIDDLE LAST
Frank Green | | | | 2a. DATE OF DEATH
MONTH DAY YEAR
2/17/82 | | 2b. HOUR
MIN.
7⁰⁰ A | |
| 3 SEX
Male | | 4 RACE
Black | | 5. DATE OF BIRTH
MONTH DAY YEAR
9 25 1907 | | 6. AGE (IN YEARS LAST BIRTHDAY)
YRS.
74 | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
S.C. | | 7b. CITIZEN OF WHAT COUNTRY?
USA | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
Baltimore, City MD. | |
| 10. CITY OR TOWN OF DEATH
Baltimore | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
Provident Hospital | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
Disabled | | 12b. KIND OF BUSINESS OR INDUSTRY | |
| 13a. STATE
Md | | | | 13b. COUNTY
Balto | | 13c. CITY OR TOWN
Balto | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
Unknown | | | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
Hannah Green | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)
No | | 16b. SOCIAL SECURITY NO.
210 03 1475 | | 17. INFORMANT
ADDRESS
Harry Green 109 Elk Hill Road Columbia S.C. | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART 1. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) CVA
4360
DUE TO, OR AS A CONSEQUENCE OF
(b) Hypertension
Conditions, if any, which gave rise to immediate cause (c), stating the underlying cause last.
(c) Atherosclerosis | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).
Diabetes | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | |
| 21d. INJURY OCCURRED
WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 2/14/82 19 82 , to 2/17/82 19 82 , that (I) (we) lost saw the deceased alive on 2/17/82 19 82 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above; (I) (we) (did) (did not) view the body after death. | | | | | | | |
| 22b. SIGNATURE
Nigel E.R. Jackman M.D. | | | | DEGREE
ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> | | 22c. DATE SIGNED
2/17/82 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
NIGEL E.R. JACKMAN | | | | 22e. ADDRESS
PROVIDENT HOSP.
2600, Liberty Hwy. Ave. - Balto. Md. | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)
Burial | | 23b. DATE
2-20-82 | | 23c. NAME OF CEMETERY OR CREMATORY
Mt. Auburn Cem | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
Baltimore, Maryland | |
| 24. FUNERAL DIRECTOR
NAME ADDRESS
Brown/Thompson FH 1913 W. Balto. St. | | | | 25a. DATE REC'D. BY REGISTRAR BY REGISTRAR
FEB 19 1982 James J. [Signature] | | | |



428 18 1885

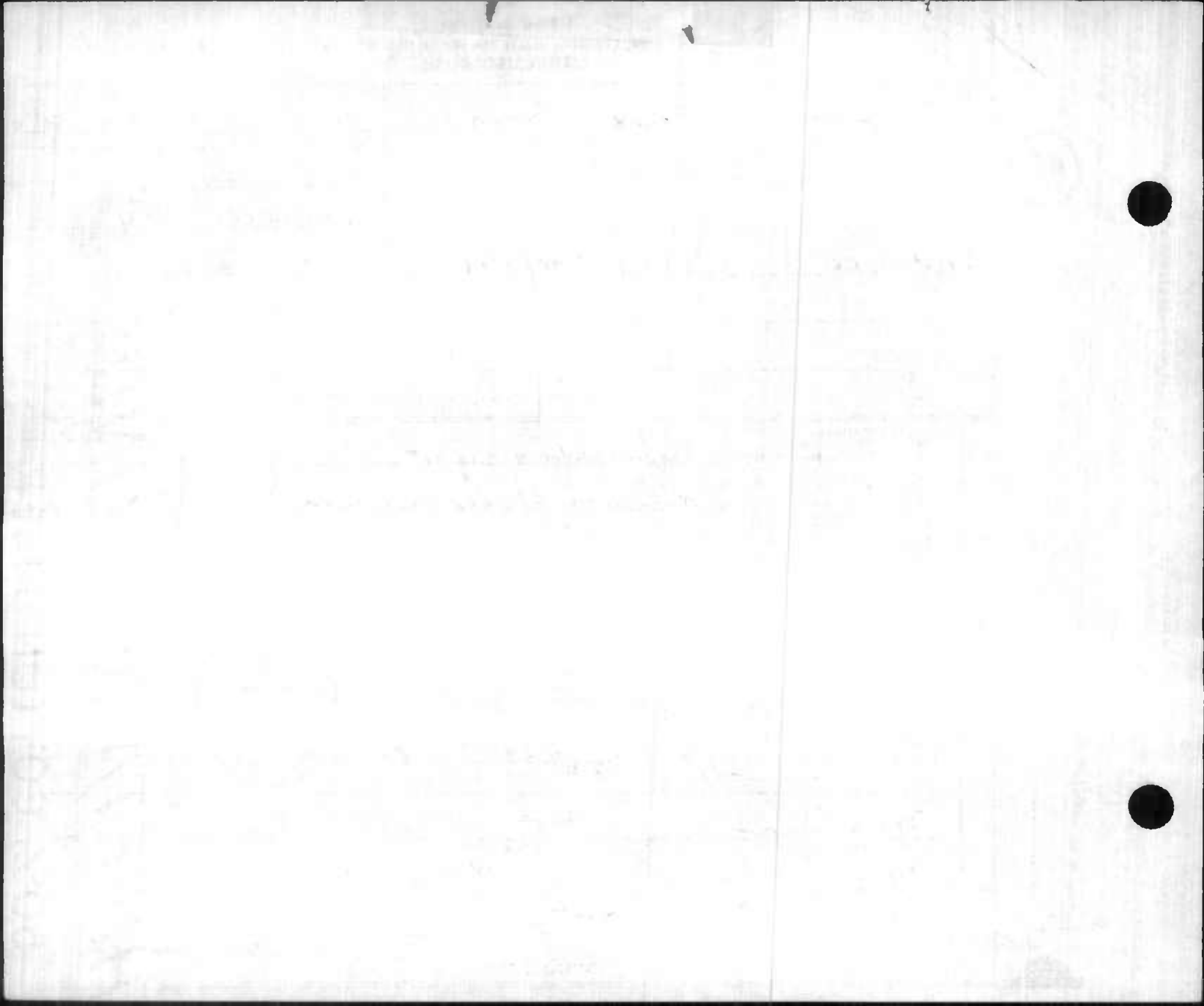
STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 2 0 3 / 7 4

1- FOR
STATE
REGISTRAR

REG. NO.

| | | | | | |
|--|---|---|---|--|---|
| 1. DECEASED NAME
(TYPE OR PRINT)
Leroy Frank Green | | | 2a. DATE OF DEATH
MONTH DAY YEAR
2/1/82 | | 2b. HOUR
6:00 P.M. |
| 3. SEX
Male | 4. RACE
Black | 5. DATE OF BIRTH
MONTH DAY YEAR
7 10 21 | | 6. AGE (IN YEARS LAST BIRTHDAY)
60 YRS. | IF UNDER 1 YEAR
MONTHS DAYS HOURS MIN. |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
S.C. | 7b. CITIZEN OF WHAT COUNTRY?
USA | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
Baltimore City MD. | |
| 10. CITY OR TOWN OF DEATH
Baltimore | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
Mercy Hospital | | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE) | |
| 13a. STATE
MD | 13b. COUNTY | 13c. CITY OR TOWN
Baltimore | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | 13e. STREET ADDRESS
3913 Bereva Ed. | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
James Green | | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
Florence Wood | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
No | | 16b. SOCIAL SECURITY NO.
244-16-3661 | | 17. INFORMANT ADDRESS
Geneva Green 3913 Bereva Rd. | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART 1. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Cardio-pulmonary arrest
1889
DUE TO, OR AS A CONSEQUENCE OF
(b) Metastatic bladder carcinoma
7 years
DUE TO, OR AS A CONSEQUENCE OF
(c) | | | | | APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATH |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a). | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | 20b. IF YES, WERE FINDINGS USED
IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | |
| 22a. I certify that (I) (this hospital) attended the deceased from 2/1/82, 19 82, to 2/1/82, 19 82, that (I) (we) last saw the deceased alive on 2/1/82, 19 82, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | |
| 22b. SIGNATURE
Marc Sokolow | | DEGREE
MD | | 22c. DATE SIGNED
2/1/82 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
Marc Sokolow | | 22e. ADDRESS
Mercy Hospital | | | |
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)
Burial | 23b. DATE
2/5/82 | 23c. NAME OF CEMETERY OR CREMATORY
Woodlawn Cem. | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
Baltimore Co. MD | |
| 24. FUNERAL DIRECTOR
NAME
Wm. C. March F/H 1101 E. North Ave. | | | 25. DATE REC'D BY REGISTRAR
FEB 3 1982 | | |



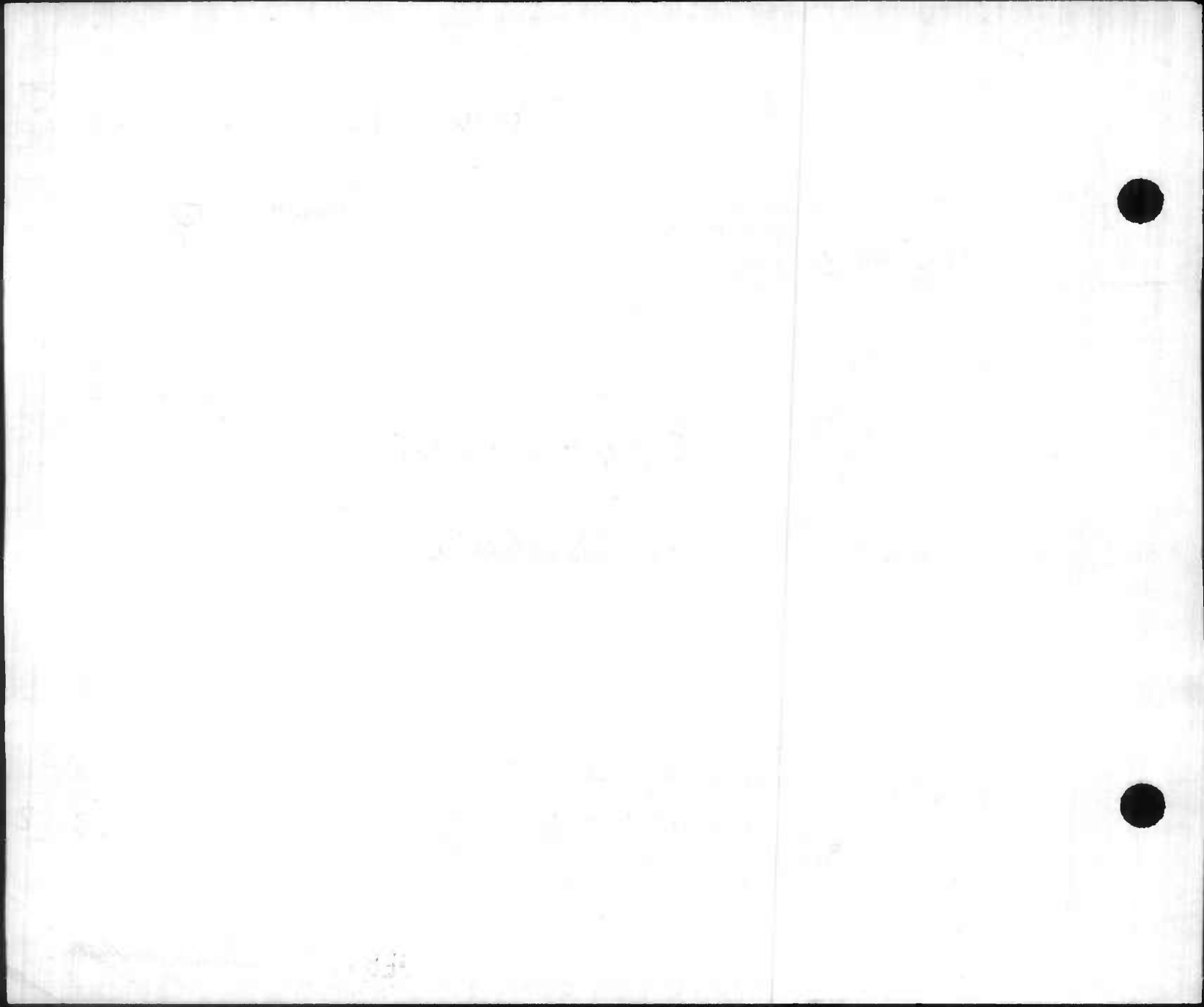
STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 2 0 3 7 7 5

1- FOR
STATE
REGISTRAR

REG. NO.

| | | | | | |
|---|--|---|---|---|--|
| 1. DECEASED NAME
(TYPE OR PRINT)
FIRST MIDDLE LAST
ULA GREEN | | | 2a. DATE OF DEATH
MONTH DAY YEAR
02 23 82 | | 2b. HOUR
845 M |
| 3. SEX
Female | 4. RACE
Black | 5. DATE OF BIRTH
MONTH DAY YEAR
9 30 01 | | 6. AGE (IN YEARS LAST BIRTHDAY)
80 YRS. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
N.C. | 7b. CITIZEN OF WHAT COUNTRY?
USA | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
Balt city MD. | |
| 10. CITY OR TOWN OF DEATH
Baltimore | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
Provident Hospital | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE) | | 12b. KIND OF BUSINESS OR INDUSTRY |
| 13a. STATE
MD | 13b. COUNTY | 13c. CITY OR TOWN
Baltimore | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | 13e. STREET ADDRESS
2307 Park Circle | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
Handy Battle | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
Mary | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
No | | 16b. SOCIAL SECURITY NO.
243-01-5581 | | 17. INFORMANT
ADDRESS
Wilk Taylor 1612 Robert Avenue
Rocky Mt., N.C. | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART 1. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Respiratory Arrest
5860
DUE TO, OR AS A CONSEQUENCE OF (b) CMT
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost
DUE TO, OR AS A CONSEQUENCE OF (c) Renal Failure | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input type="checkbox"/> | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | |
| 21d. INJURY OCCURRED
WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | |
| 22a. I certify that (I) (this hospital) attended the deceased from 2-23 19 82 to 2-23 19 82 that (I) (we) lost
saw the deceased alive on 2-23 19 82 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated
above, (I) (we) (did) (did not) view the body after death. | | | | | |
| 22b. SIGNATURE
Isaiah D. March | | DEGREE
MD | | 22c. DATE SIGNED
2-23-82 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
ISAIAH D. MARCH | | 22e. ADDRESS
2600 Liberty Hts | | | |
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)
Burial | 23b. DATE
2/27/82 | 23c. NAME OF CEMETERY OR CREMATORY
Northeastern Cem. | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
Rocky Mt. N.C. | |
| 24. FUNERAL DIRECTOR
NAME
Wm. C. March F/H | | ADDRESS
1101 E. North Ave. | | 25a. DATE REC'D. BY REGISTRAR
FEB 25 1982 | 25b. REGISTRAR'S SIGNATURE
Thomas J. [Signature] |



STATE OF MARYLAND

DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 2 0 3 7 7 6

REG. NO.

| | | | | | | | |
|--|--|--|--|---|--|---|--|
| 1. FOR
STATE
REGISTRAR | | 1. DECEASED NAME
(TYPE OR PRINT) | | 2a. DATE OF DEATH | | 2b. HOUR | |
| | | ROBERT S. GREEN | | FEBRUARY 18, 1982 | | 2:52AM | |
| 3. SEX | | 4. RACE | | 5. DATE OF BIRTH | | 6. AGE (IN YEARS LAST BIRTHDAY) | |
| Male | | White | | 8 16 1980 | | 1 YRS. | |
| 7. BIRTHPLACE
(COUNTRY) | | 7b. CITIZEN OF WHAT COUNTRY? | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH | |
| Maryland | | U.S.A. | | | | BALTIMORE CITY MD. | |
| 10. CITY OR TOWN OF DEATH | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE) | | 12b. KIND OF BUSINESS OR INDUSTRY | |
| Baltimore | | JOHNS HOPKINS HOSPITAL | | Dependent | | | |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) | | 13b. CITY OR TOWN | | 13c. INSIDE CITY LIMITS? | | 13d. STREET ADDRESS | |
| Maryland | | Baltimore | | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 216 Ashwood Road | |
| 14. FATHER'S NAME | | 15. MOTHER'S MAIDEN NAME | | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN) | | 16b. SOCIAL SECURITY NO. | |
| Kenneth | | Cindy | | No | | | |
| 17. INFORMANT | | 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART 1. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>CARDIO RESPIRATORY ARREST</u>
<u>7452</u>
DUE TO, OR AS A CONSEQUENCE OF
(b) <u>LOW CARDIAC OUTPUT SYNDROME</u>
DUE TO, OR AS A CONSEQUENCE OF
(c) <u>OPERATIVE REPAIR TETRALOGY OF FALLOT</u> | | 19. DATE OF OPERATION | | 20. AUTOPSY? | |
| Cindy Green | | | | Feb. 17 1982 | | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| ADDRESS 216 Ashwood Rd.
Balto., MD. 21222 | | | | | | 21. IF YES, WERE FINDINGS USED
IN CERTIFYING CAUSES OF DEATH? | |
| | | | | | | YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| | | | | | | 22. SIGNATURE | |
| | | | | | | 23. DATE SIGNED | |
| | | | | | | 2/18/82 | |
| | | | | | | 24. PHYSICIAN'S NAME (TYPE OR PRINT) | |
| | | | | | | JOHN A.G. SAMPSON | |
| | | | | | | 25. ADDRESS | |
| | | | | | | JOHNS HOPKINS HOSP. Balt Md | |
| | | | | | | 26. BURIAL, CREMATION, REMOVAL
(SPECIFY) | |
| | | | | | | Burial | |
| | | | | | | 27. DATE | |
| | | | | | | 2/22/1982 | |
| | | | | | | 28. NAME OF CEMETERY OR CREMATORY | |
| | | | | | | Holly Hill | |
| | | | | | | 29. LOCATION
CITY OR TOWN | |
| | | | | | | White Marsh | |
| | | | | | | COUNTY | |
| | | | | | | Maryland | |
| | | | | | | 30. FUNERAL DIRECTOR
NAME | |
| | | | | | | Duda-Ruck, Inc. | |
| | | | | | | ADDRESS | |
| | | | | | | 7922 Wise Avenue Dundalk, MD. 21222 | |
| | | | | | | 31. DATE REC'D BY REGISTRAR | |
| | | | | | | FEB 22 1982 | |
| | | | | | | 32. REGISTRAR'S SIGNATURE | |
| | | | | | | James J. Nathan | |

Q



FOR
1 - STATE
REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

8 2 0 3 7 7 7

| | | | | | | | |
|---|--|--|---|---|---|---|--|
| 1. DECEASED NAME
(TYPE OR PRINT)
FIRST MIDDLE LAST
Cecil M. Greene Sr | | | 2a. DATE OF DEATH
MONTH DAY YEAR
2 13 1982 | | | 2b. HOUR
M
AM | |
| 3. SEX
male | | 4. RACE
black | | 5. DATE OF BIRTH
MONTH DAY YEAR
6 21 1904 | | 6. AGE (IN YEARS LAST BIRTHDAY)
77 YRS | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
Miss | | 7b. CITIZEN OF WHAT COUNTRY?
USA | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
Baltimore city MD | |
| 10. CITY OR TOWN OF DEATH
Baltimore | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
5115 Herring Run Drive | | | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE) | |
| 13a. STATE
Md | | 13b. COUNTY | | 13c. CITY OR TOWN
Baltimore | | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
John Greene | | | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
Belle L. Johnson | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES NO OR UNKNOWN)
No | | 16b. SOCIAL SECURITY NO.
427-36-6958 | | 17. INFORMANT
ADDRESS
Cecil M. Greene Jr 5115 Herring Run Drive | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) H.C.V.D.
4029
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b) atherosclerosis
DUE TO, OR AS A CONSEQUENCE OF
(c) _____ | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: _____ | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY BY ITEM 18, PART 1 OR PART 2) | | | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK AT WORK | | 21e. PLACE OF INJURY
(AT HOME STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | |
| 22. I certify that (I) (the hospital) attended the deceased from Sept 9, 1981 to February 13, 1982 that (I) (last) saw the deceased alive on January 19, 1982 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (do) view the body after death. | | | | | | | |
| 22a. SIGNATURE
Jesse T. Holmes MD | | | | DEGREE
M.D. | | 22c. DATE SIGNED
2/15/82 | |
| 22b. PHYSICIAN'S NAME (TYPE OR PRINT)
Jesse T. Holmes MD | | | | 22e. ADDRESS
2300 Garrison Blvd, Balto, Md. | | | |
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)
Burial | | 23b. DATE
2/17/82 | | 23c. NAME OF CEMETERY OR CREMATORY
LIVE OAK Church Cem | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
Pass Christian Miss | |
| 24. FUNERAL DIRECTOR
NAME
William C. March F/H 1101 E. North Avenue | | | | 25a. DATE REC'D. BY REGISTRAR
FEB 16 1982 | | | |
| | | | | 25b. REGISTRAR'S SIGNATURE
Ramon J. [Signature] | | | |

MEDICAL CERTIFICATION

61
35
300
1
9
9

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 1 must be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

15th 1878
and 10th 1878

1878 10th 1878

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 2 0 3 7 7 8

REG. NO.

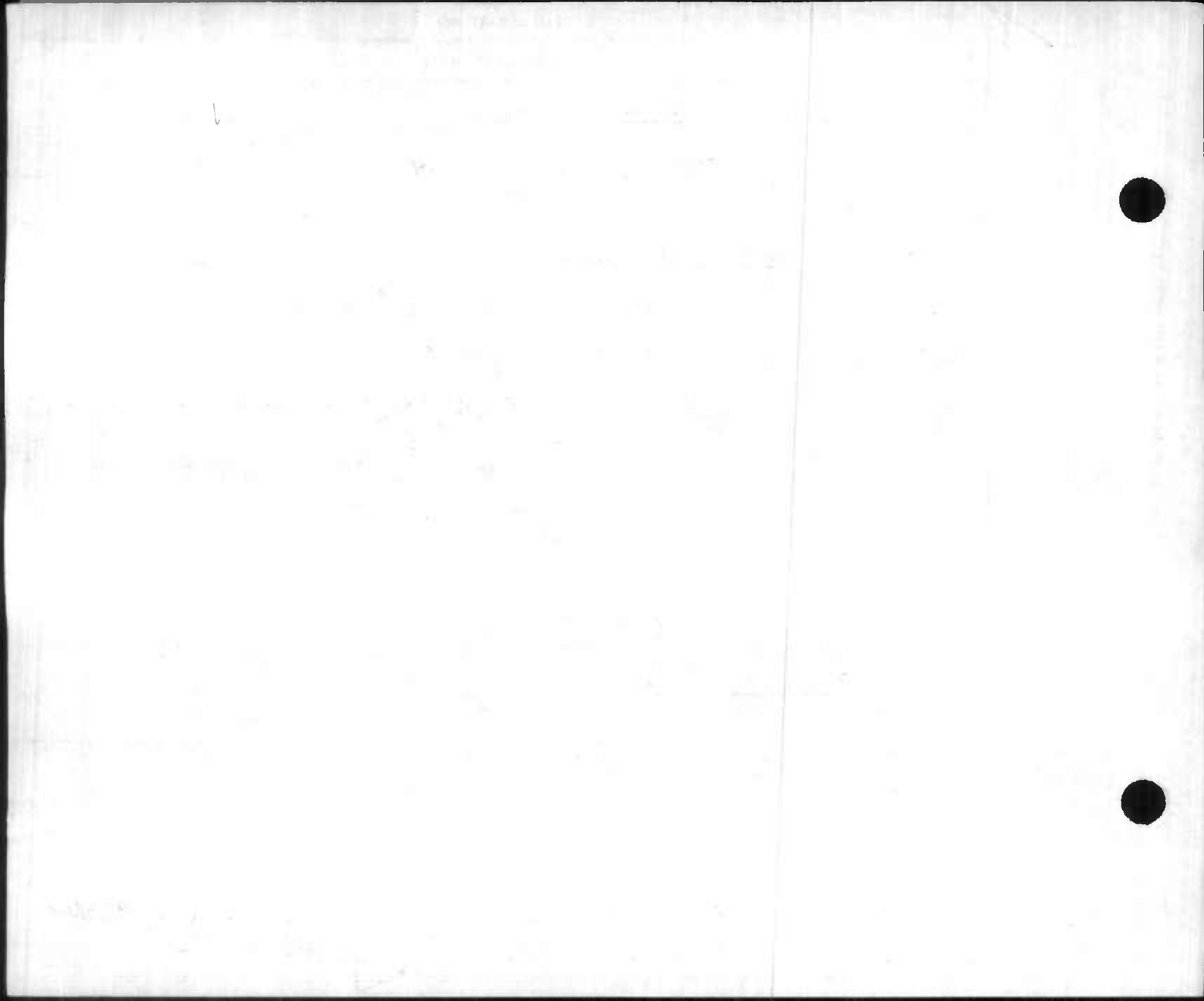
1. FOR
STATE
REGISTRAR

| | | | | | | | | | | | |
|--|--|--|--|---|--|--|---|--|--|---|--|
| 1. DECEASED NAME
(TYPE OR PRINT)
ELMER WILLIAM GREENE | | | 2a. DATE OF DEATH
MONTH 2 DAY 21 YEAR 82 | | | 2b. HOUR
M | | | | | |
| 3. SEX
MALE | | 4. RACE
BLACK | | 5. DATE OF BIRTH
MONTH 11 DAY 11 YEAR 09 | | 6. AGE (IN YEARS LAST BIRTHDAY)
72 YRS | | 7. IF UNDER 1 YEAR
MONTHS 0 DAYS 0 | | 8. IF UNDER 24 HRS
HOURS 0 MIN 0 | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
north carolina | | 7b. CITIZEN OF WHAT COUNTRY?
usa | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
Baltimore city MD. | | | | | |
| 10. CITY OR TOWN OF DEATH
Balto. | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
501 Dolphin Street | | | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE) | | 12b. KIND OF BUSINESS OR INDUSTRY | | | |
| 13a. STATE
Md. | | | 13b. COUNTY | | 13c. CITY OR TOWN
Balto. | | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS
501 Dolphin Street | | |
| 14. FATHER'S NAME
FIRST William MIDDLE Greene LAST Sophronia | | | 15. MOTHER'S MAIDEN NAME
FIRST Sophronia MIDDLE Greene LAST Greene | | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
No | | | 16b. SOCIAL SECURITY NO.
237 05 6503 | | 17. INFORMANT
ADDRESS
Frances Greene 501 Dolphin St. Apt. 901 | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART 1. DEATH WAS CAUSED BY:
1850 Metastatic Carcinoma of Prostate
IMMEDIATE CAUSE (a) 1850
DUE TO, OR AS A CONSEQUENCE OF (b) Prostate
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (c) Prostate
DUE TO, OR AS A CONSEQUENCE OF (c) Prostate | | | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a): | | | | | | | | | | | |
| 19a. DATE OF OPERATION
6 months ago | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED
Prostate Obstruction | | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | | |
| 21a. ACCIDENT WAS UNDERLYING CAUSE OF CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | 21b. TIME OF INJURY
HOUR A.M. MONTH 11 DAY 19 YEAR 82 | | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | | | |
| 21d. INJURY OCCURRED
WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | | 21f. LOCATION
STREET 1850 CITY OR TOWN BALTO. COUNTY MD. STATE MD. | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 1 month ago to 2/21/82 , that (I) (we) lost saw the deceased alive on 2/21/82 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | | | |
| 22b. SIGNATURE
Benjamin I. Opara MD | | | DEGREE
MD | | | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | | 22c. DATE SIGNED
2/25/82 | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
BENJAMIN I. OPARA | | | 22e. ADDRESS
2300 Garrison Blvd. Balto. Md | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)
BURIAL | | | 23b. DATE
2/26/82 | | 23c. NAME OF CEMETERY OR CREMATORY
KING MEMORIAL PK | | 23d. LOCATION
CITY OR TOWN BALTO., MD. COUNTY MD. STATE MD. | | 23e. DATE REC'D BY REGISTRAR
FEB 23 1982 | | |
| 24. FUNERAL DIRECTOR
NAME LEROY O. DYETT ADDRESS 4600 LIBERTY HEIGHTS AVE. | | | | | | | | | | | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours of death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified by the



TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, Pages 1 and 2 should be filed with the health officer after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.1. FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 2 0 3 7 7 9

REG. NO.

| | | | | | | |
|--|--|---|--|---|---------------------|--|
| 1. DECEASED NAME
(TYPE OR PRINT)
FIRST MIDDLE LAST
ERNEST LAMONT GREENE | | | 2a. DATE OF DEATH
MONTH DAY YEAR
2 24 82 | | 2b. HOUR
4:00 am | |
| 3. SEX
MALE | | 4. RACE
BLACK | | 5. DATE OF BIRTH
MONTH DAY YEAR
12 10 18 | | |
| 7a. BIRTHPLACE
(STATE OR FOREIGN COUNTRY)
NEBRASKA | | 7b. CITIZEN OF WHAT COUNTRY?
U.S.A. | | 6. AGE (IN YEARS (LAST BIRTHDAY))
63 YRS | | |
| 10. CITY OR TOWN OF DEATH
BALTIMORE | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
VAMC BALTIMORE, MARYLAND 21218 | | 9. BALTIMORE CITY OR COUNTY OF DEATH
BALTIMORE CITY MD | | |
| 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
CHEF | | 12b. KIND OF BUSINESS OR INDUSTRY | | | | |

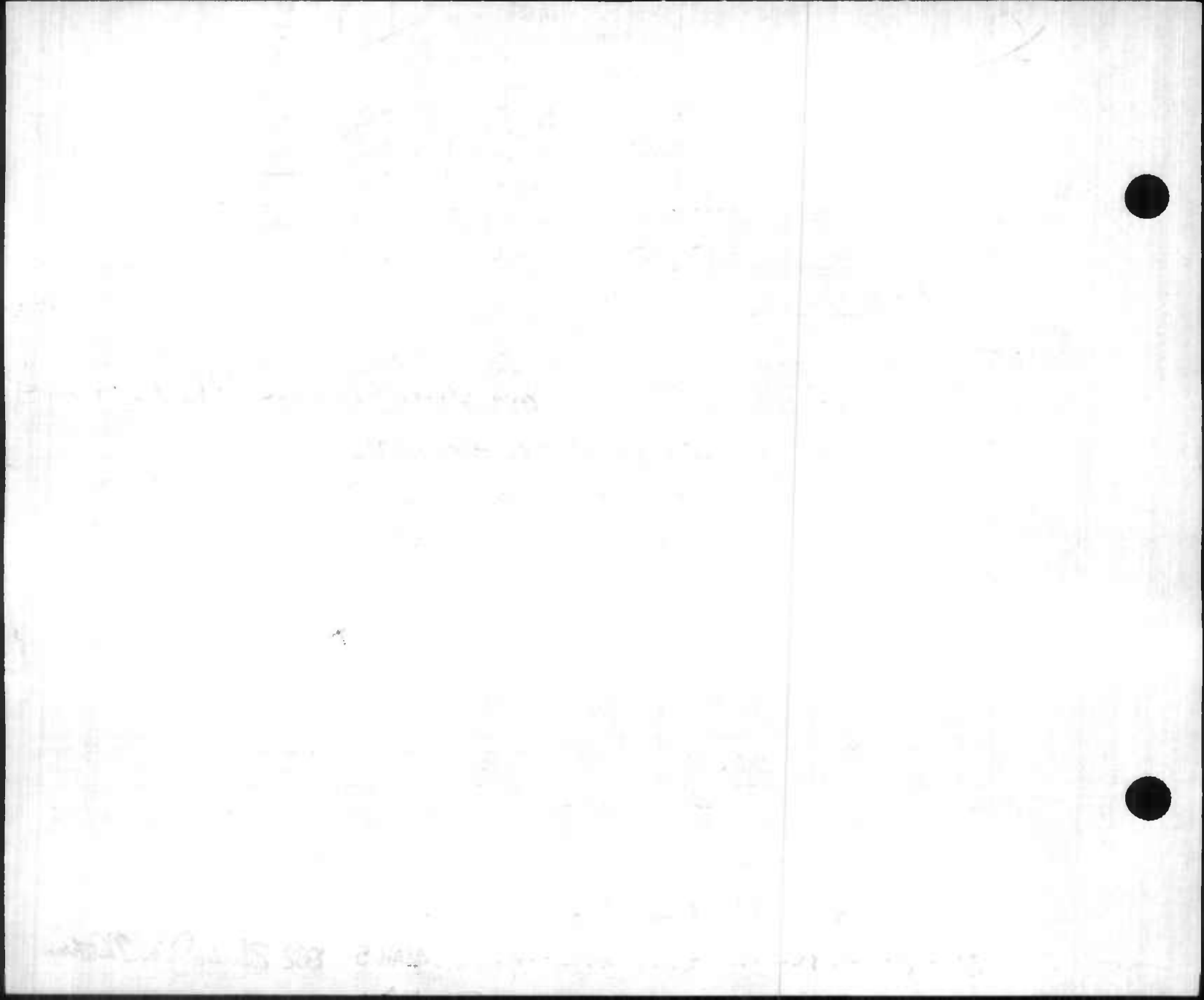
| | | | | | | | | | | |
|---|--|--|---|--|--------------------------------|---|---|--|--|--|
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)
STATE
MARYLAND | | | 13b. COUNTY
BALTIMORE | | 13c. CITY OR TOWN
BALTIMORE | | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS
311 N CHARLES ST. Ave | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
JOE GREENE | | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
SOPHRONIA KENNEY | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(IF YES, GIVE WAR OR DATES)
YES | | | 16b. SOCIAL SECURITY NO.
712 12 1106 | | | 17. INFORMANT
ADDRESS
Mrs Viola Greene 311 Charles St Ave | | | | |

| | | | |
|--|--|---|--|
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART 1. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>Respiratory Arrest</u>
1629
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last
(b) <u>Hemoptysis</u>
(c) <u>Adenocarcinoma, RLL Lung</u> | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
Unknown
2 months since Dx. | |
|--|--|---|--|

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:

| | | | | | | | |
|--|--|--|--|--|--|--|--|
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | |
| 22a. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <u>Feb. 22</u> , 19 <u>82</u> to <u>Feb. 24</u> , 19 <u>82</u> that <input checked="" type="checkbox"/> (we) last saw the deceased alive on <u>Feb. 24</u> , 19 <u>82</u> , and that in <input checked="" type="checkbox"/> (our) opinion death occurred on the date and hour and from the causes stated above. <input checked="" type="checkbox"/> (we) (did) <input checked="" type="checkbox"/> (not) view the body after death. | | | | | | | |
| 22b. SIGNATURE
<u>Robert Barthel MD</u> | | | | DEGREE | | 22c. DATE SIGNED
2/24/82 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
Robert Barthel | | | | 22e. ADDRESS
3900 LOCH RAVEN BLVD., BALTO, MD 21218 | | | |

| | | | | | | | |
|--|--|---------------------|--|---|--|---|--|
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)
13 | | 23b. DATE
3/1/82 | | 23c. NAME OF CEMETERY OR CREMATORY
Crownsville | | 23d. LOCATION
CITY OR TOWN COUNTY STATE | |
| 24. FUNERAL DIRECTOR
NAME
Joseph L. Run | | | | ADDRESS
2222-26 W York | | 25a. DATE REC'D. BY REGISTRAR
MAR 5 1982 | |
| | | | | 25b. REGISTRAR'S SIGNATURE
James J. Barthel | | | |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 24 hours of death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH | | | | | | | | | | REG. NO. | |
|--|--|--|--|--|---|---|--|--|---|---|--|
| 1- FOR STATE REGISTRAR | | | | | | | | | | 8 2 0 3 / 8 0 | |
| 1 DECEASED NAME (TYPE OR PRINT)
FIRST MIDDLE LAST
ALBERT GRIFFIN | | | | | 2a DATE OF DEATH
MONTH DAY YEAR
2 26 82 | | 2b HOUR
4:30 AM | | | | |
| 3 SEX
MALE | | 4 RACE
BLACK | | 5 DATE OF BIRTH
MONTH DAY YEAR
2 29 20 | | 6 AGE (IN YEARS LAST BIRTHDAY)
61 | | IF UNDER 1 YEAR
MONTHS DAYS HOURS MIN.
YRS. | | IF UNDER 24 HRS. | |
| 7a BIRTHPLACE (STATE OR FOREIGN COUNTRY)
BALTIMORE MD | | 7b CITIZEN OF WHAT COUNTRY?
U.S.A. | | 8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9 BALTIMORE CITY OR COUNTY OF DEATH
Baltimore City MD. | | | | | |
| 10 CITY OR TOWN OF DEATH
BALTIMORE, MD | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
UNIV. OF MARYLAND HOSPITAL | | | | 12a USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
LABORER | | 12b KIND OF BUSINESS OR INDUSTRY
ELECTRIC | | | |
| 13a USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)
13a STATE
MD | | | 13b COUNTY
BALTIMORE | | 13c CITY OR TOWN
BALTIMORE | | 13d INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e STREET ADDRESS
4215 DORCHESTER ROAD | | |
| 14 FATHER'S NAME
FIRST MIDDLE LAST
HERMAN GRIFFIN | | | | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
FLORA JONES GRIFFIN | | | | | | |
| 16a WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
No | | | 16b SOCIAL SECURITY NO.
(IF YES, GIVE WAR OR DATES)
212-18-4886 | | 17 INFORMANT
ADDRESS
SON - ALONZO GRIFFIN | | | | | | |
| 18 CAUSE OF DEATH (Enter one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY.
IMMEDIATE CAUSE (a) PULMONARY EDEMA
1991
DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b) Metastatic Carcinoma - Unknown Origin
DUE TO, OR AS A CONSEQUENCE OF
(c) Chronic Renal Failure | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
hours
months
years | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)
Hypertension, Hyperparathyroidism | | | | | | | | | | | |
| 19a DATE OF OPERATION
NONE | | | 19b CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | | |
| 21a ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | | 21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | | | |
| 21d INJURY OCCURRED
WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | | 21f LOCATION
STREET CITY OR TOWN COUNTY STATE | | | | | |
| 22a. I certify that (this hospital) attended the deceased from 2/26 , 19 77 , to 2/26 , 19 82 , that (we) last saw the deceased alive on 2/26 , 19 82 , and that in (our) opinion death occurred on the date and hour and from the causes stated above. (We) did (not) view the body after death. | | | | | | | | | | | |
| 22b SIGNATURE
David S. Prince MD | | | | | DEGREE
MD | | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | 22c DATE SIGNED
2/26/82 | | |
| 22d PHYSICIAN'S NAME (TYPE OR PRINT)
DAVID S. PRINCE MD | | | | | 22e ADDRESS
University of Maryland Hospital | | | | | | |
| 23a BURIAL, CREMATION, REMOVAL (SPECIFY)
Burial | | | 23b DATE
3/2/82 | | 23c NAME OF CEMETERY OR CREMATORY
Cedar Hill Cem. | | | 23d LOCATION
CITY OR TOWN COUNTY STATE
Anne Arundel Co., Md. | | | |
| 24 FUNERAL DIRECTOR
NAME
Wm C March F/H, Inc. | | | | | ADDRESS
1101 E. North Ave. | | 25a DATE REC'D. BY REGISTRAR
MAR 1 1982 | | 25b REGISTRAR'S SIGNATURE
Phonca Jan Kuthan | | |

19

[Faint, illegible handwriting throughout the page, possibly bleed-through from the reverse side. The text is mostly mirrored across a vertical line.]

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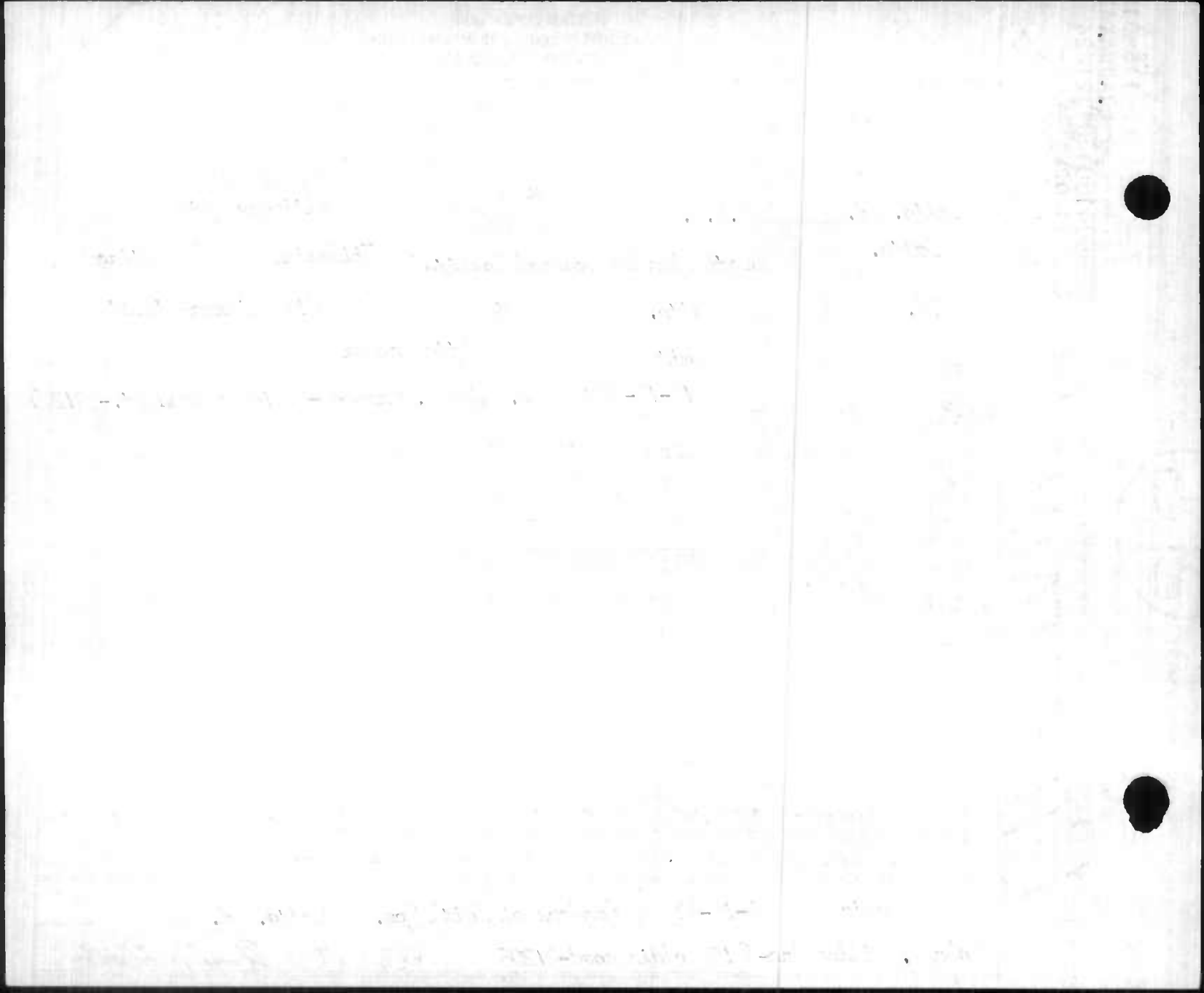
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IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

| STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH | | | | REG. NO. 00041801 01 21224 | | | |
|---|--|---|--|---|--|--|--|
| 1. FOR STATE REGISTRAR | | | | 2614 ORLEANS ST 3 | | | |
| 1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST
VIOLA C. GROPPE | | | | 2a. DATE OF DEATH MONTH DAY YEAR
FEB. 13 1982 | | | |
| 3. SEX
FEMALE | | | | 4. RACE
WHITE | | 5. DATE OF BIRTH MONTH DAY YEAR
JUNE 28 1900 | |
| 6. AGE (IN YEARS LAST BIRTHDAY)
81 YRS. | | | | IF UNDER 1 YEAR MONTHS DAYS
0 0 | | IF UNDER 24 HRS. HOURS MIN.
4 35 | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
Balto. Md. | | 7b. CITIZEN OF WHAT COUNTRY?
U.S.A. | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
Baltimore City MD. | |
| 10. CITY OR TOWN OF DEATH
Balto. | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
North Charles General Hospital | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)
Tailoring | | 12b. KIND OF BUSINESS OR INDUSTRY
Retired | |
| 13a. STATE
Md. | | | | 13b. COUNTY
Balto. | | 13c. CITY OR TOWN
Balto. | |
| 14. FATHER'S NAME FIRST MIDDLE LAST
Smith | | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST
Etta Bremer | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)
No | | | | 16b. SOCIAL SECURITY NO.
214-18-0289 | | 17. INFORMANT ADDRESS
Mr. Adam F. Groppe - 2614 Orleans St. - 21224 | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
1889
IMMEDIATE CAUSE (a) RENAL FAILURE
DUE TO, OR AS A CONSEQUENCE OF (b) BLADDER TUMOR WITH METASTASES TO LIVER, LUNGS & SKULL
DUE TO, OR AS A CONSEQUENCE OF (c) ANEMIA | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)
ANEMIA | | | | | | | |
| 19a. DATE OF OPERATION
2-8-82 | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED
HEMATURIA | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from JAN- 26 , 19 82 , to FEB. 13 , 19 82 , that (I) (we) last saw the deceased alive on FEB. 13 , 19 82 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | |
| 22b. SIGNATURE
C. VERGARA-SOARES | | | | DEGREE
M.D.
ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> | | 22c. DATE SIGNED
2-13-82 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
C. VERGARA-SOARES | | | | 22e. ADDRESS
N. CHARLES GEN. HOSP. BALT. MD. 21218 | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)
Burial | | 23b. DATE
2-16-82 | | 23c. NAME OF CEMETERY OR CREMATORY
Gardens of Faith Cem. | | 23d. LOCATION CITY OR TOWN COUNTY STATE
Balto. Md. | |
| 24. FUNERAL DIRECTOR NAME ADDRESS
John C. Miller Inc-6415 Belair Road-21206 | | | | 25a. DATE REC'D. BY REGISTRAR 25b. REGISTRAR'S SIGNATURE
FEB 16 1982 | | | |

VIOLA C. GROPPE
012 8TFW 115-01224
1274447
21224
ST
2614 ORLEANS ST



TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR OR PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

**STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH**

REG. NO.

1- FOR
STATE
REGISTRAR

| | | | | | | | | | | | |
|--|-------------------------|---|--|---|--|---|--|--|--|---|--|
| 1. DECEASED NAME
(TYPE OR PRINT)
DR. Jack | | FIRST
Grosman | | MIDDLE
Grosman | | LAST
Grosman | | 2a. DATE KNOWN OF DEATH
ESTIMATED <input checked="" type="checkbox"/> MONTH DAY YEAR
2 9 1982 | | 2b. HOUR
M | |
| 3. SEX
Male | 4. RACE
White | 5. DATE OF BIRTH
MONTH DAY YEAR
OCT. 12, 1920 | 6. AGE (IN YEARS)
LAST BIRTHDAY
61 YRS. | IF UNDER 1 YR.
MONTHS DAYS HOURS MIN
XX | IF UNDER 24 HRS.
MONTHS DAYS HOURS MIN
XX | 2c. DATE PRONOUNCED DEAD
MONTH DAY YEAR
2 9 1982 | | 2d. HOUR
5:40 P. M. | | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
MASSACHUSETTS | | 7b. CITIZEN OF WHAT COUNTRY?
USA | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
Baltimore City, MD | | | | | |
| 10. CITY OR TOWN OF DEATH
Baltimore | | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
Sinai Hospital | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)
PROFESSOR | | 12b. KIND OF BUSINESS OR INDUSTRY
EDUCATION | | | |
| USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) | | | | | | | | | | | |
| 13a. STATE
MARYLAND | | 13b. COUNTY
BALTO. | | 13c. CITY OR TOWN
BALTIMORE | | 13d. INSIDE CITY LIMITS?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 13e. STREET ADDRESS
3614 OAK AVE. | | #21207 | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
MORRIS GROSMAN | | | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
ELIZABETH RAFKIN | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO, OR UNKNOWN)
YES | | | | 16b. SOCIAL SECURITY NO.
220-05-5037 | | 17. INFORMANT MRS. HARRIET GROSMAN
3614 OAK AVE. BALTO., MD 21207 | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I DEATH WAS CAUSED BY:
9571
Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.
IMMEDIATE CAUSE (a) Multiple Injuries
(b) _____
(c) _____
DUE TO, OR AS A CONSEQUENCE OF
DUE TO, OR AS A CONSEQUENCE OF | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | | | | | | | | 20. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH | | 21b. TIME OF INJURY approx. HOUR 5:15 P.M. MONTH 2 DAY 9 YEAR 1982 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)
subject jumped out of window | | | | | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input checked="" type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)
hospital | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE
Belvedere & Greenspring Aves., Balto., Md. | | | | | | | |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> . | | | | | | | | | | | |
| ACTUAL SIGNATURE
Virginia L. Dolan | | TITLE (SPECIFY)
M.D. Assistant | | | | MEDICAL EXAMINER | | DATE SIGNED 2-10-82 | | | |
| EXAMINER'S NAME
(TYPE OR PRINT)
Virginia L. Dolan, M.D. | | ADDRESS 111 Penn Street | | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)
BURIAL | | 23b. DATE
FEB. 11, 1982 | | 23c. NAME OF CEMETERY OR CREMATORY
BNAI ISRAEL | | | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
BALTIMORE MARYLAND | | | |
| 24. FUNERAL DIRECTOR
NAME ADDRESS
SOL LEVINSON & BROS., INC.
6010 REISTERSTOWN RD. BALTO., MD 21215 | | 25a. DATE REC'D. BY REGISTRAR
FEB 17 1982 | | 25b. REGISTRAR'S SIGNATURE
Thomas Jan Posth | | | | | | | |

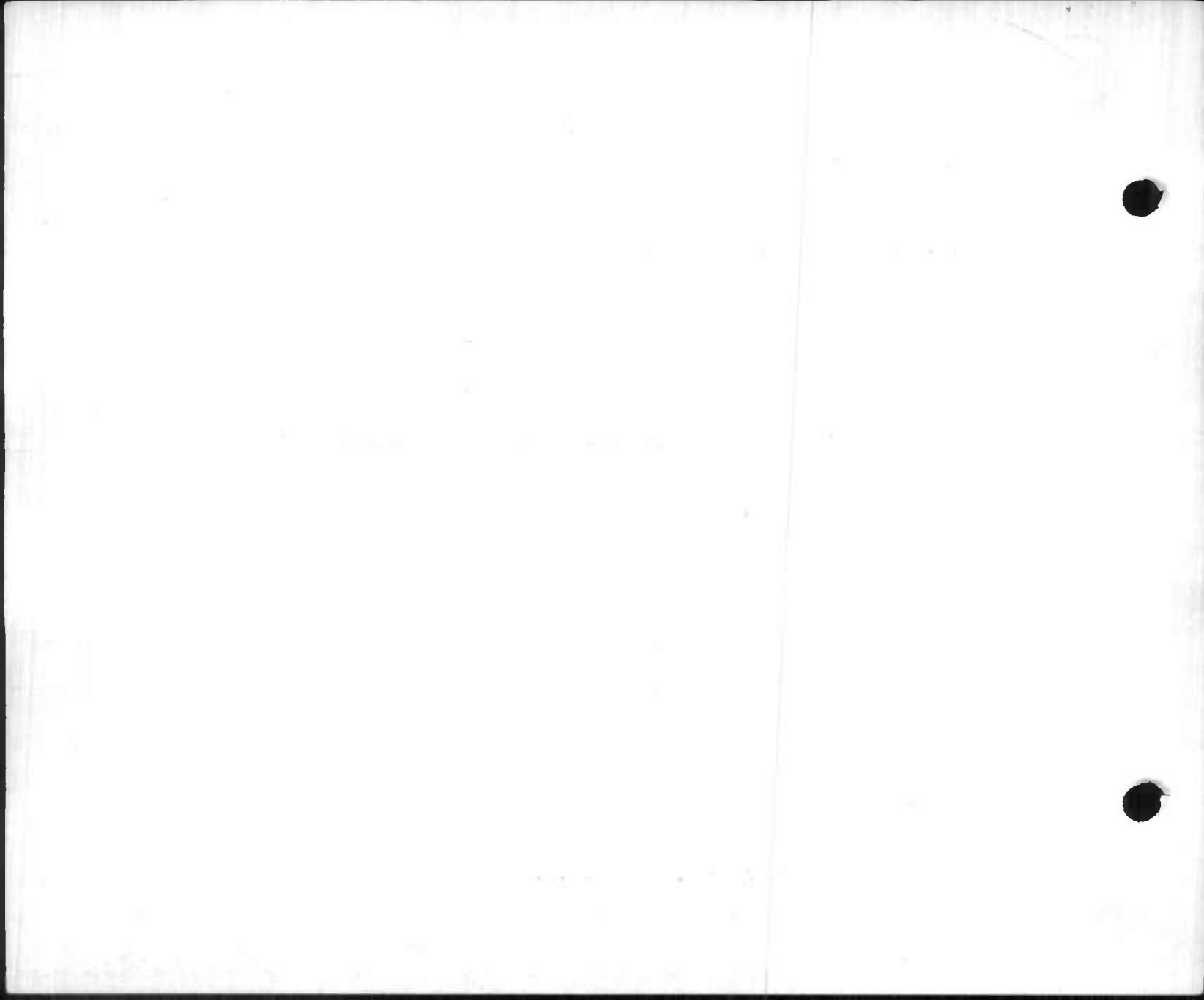
BP

1948-1949 1948-1949

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING TO THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

MEDICAL CERTIFICATION

| STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH | | | | | | | | | | REG. NO. 8 2 0 3 7 8 3 | | | |
|---|--|-------------------------|--|---|--|---|--|---|--|---|--|------------------------------|--|
| 1. DECEASED NAME
(TYPE OR PRINT) FIRST MIDDLE LAST
CLIFTON GROSS | | | | | | | | | | 2a. DATE KNOWN OF DEATH
MONTH DAY YEAR
2-4-82 19 | | 2b. HOUR
M
3:05 | |
| 3. SEX
male | | 4. RACE
black | | 5. DATE OF BIRTH
MONTH DAY YEAR
9 11 98 | | 6. AGE (IN YEARS)
(LAST BIRTHDAY) MONTHS DAYS
83 YRS. | | IF UNDER 1 YR. MONTHS DAYS
IF UNDER 24 HRS. HOURS MIN. | | 2c. DATE PRONOUNCED DEAD
MONTH DAY YEAR
2-4-82 19 | | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
MD | | | | 7b. CITIZEN OF WHAT COUNTRY?
USA | | | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
Baltimore City MD | | | |
| 10. CITY OR TOWN OF DEATH
Baltimore | | | | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
1809 Walbrook Avenue | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | | 12b. KIND OF BUSINESS OR INDUSTRY | | | |
| 13a. STATE
MD | | | | 13b. COUNTY | | 13c. CITY OR TOWN
Baltimore | | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS
1809 Walbrook Avenue | | | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
Wyatt Gross | | | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
Lucy Brooks | | | | 16. ADDRESS
1098 Lincoln Pl. Clifton E. Gross Bklyn, N.Y. | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO, OR UNKNOWN) (IF YES, GIVE WAR OR DATES)
Yes | | | | 16b. SOCIAL SECURITY NO.
215-05-0545 | | 17. INFORMANT
Clifton E. Gross | | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Arteriosclerotic cardiovascular disease
4292 } DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause lost. }
(b) }
(c) }
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a): | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | | |
| 19a. DATE OF OPERATION | | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | | | | | | 20. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH | | | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) | | | | | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK AT WORK | | | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | | | | | |
| 22a. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> . | | | | | | | | | | | | | |
| ACTUAL SIGNATURE
<i>Margarita A. Koroll</i> | | | | TITLE (SPECIFY)
Assistant | | | | DATE SIGNED
2-5-82 | | | | | |
| EXAMINER'S NAME
(TYPE OR PRINT)
Margarita A. Koroll, M.D. | | | | ADDRESS
111 Penn Street | | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)
Cremation | | | | 23b. DATE
12/11/82 | | 23c. NAME OF CEMETERY OR CREMATORY
Westview Mem. Pk. | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
Baltimore Co. MD | | | | | |
| 24. FUNERAL DIRECTOR
NAME ADDRESS
Wm. C. March F/H 1101 E. North Ave. | | | | 25a. DATE REC'D. BY REGISTRAR
FEB 11 1982 | | 25b. REGISTRAR'S SIGNATURE
<i>[Signature]</i> | | | | | | | |





TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death and retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

DHMH-16 50M 1/81
(VRA 15, 4)

| STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH | | | | | | | | | |
|--|--|--|--|---|--|--|--|--|--|
| 1- STATE REGISTRAR <u>Werner L. Gruber Sr.</u> | | | | | | | | | |
| 1 DECEASED NAME (TYPE OR PRINT) <u>Werner L. Gruber Sr.</u> | | | | | | 2a DATE OF DEATH MONTH <u>2-11-82</u> DAY <u>10</u> YEAR <u>Am</u> | | 2b HOUR | |
| 3 SEX <u>Male</u> | | 4 RACE <u>White</u> | | 5 DATE OF BIRTH MONTH <u>Oct. 7, 1896</u> YEAR | | 6 AGE (IN YEARS LAST BIRTHDAY) <u>85</u> YRS. | | IF UNDER 1 YEAR MONTHS DAYS HOURS MIN. | |
| 7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) <u>Md.</u> | | 7b CITIZEN OF WHAT COUNTRY? <u>USA</u> | | 8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9 BALTIMORE CITY OR COUNTY OF DEATH <u>City</u> MD. | | | |
| 10 CITY OR TOWN OF DEATH <u>Baltimore</u> | | 11 NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <u>John L. Deaton Medical Center</u> | | | | 12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <u>Ret. Clothing Designer</u> | | 12b KIND OF BUSINESS OR INDUSTRY | |
| 13a STATE <u>Md.</u> | | 13b COUNTY | | 13c CITY OR TOWN <u>Baltimore</u> | | 13d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e STREET ADDRESS <u>1661 E. Northern Pkway</u> | |
| 14 FATHER'S NAME FIRST <u>Ludwig</u> MIDDLE LAST <u>Gruber</u> | | | | 15 MOTHER'S MAIDEN NAME FIRST <u>Katherine</u> MIDDLE LAST <u>Stadler</u> | | | | | |
| 16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <u>no</u> | | 16b SOCIAL SECURITY NO. <u>216-01-7068</u> | | 17 INFORMANT ADDRESS <u>Mrs. Myrtle GRuber Same</u> | | | | | |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART 1. DEATH WAS CAUSED BY:
<u>1539</u> IMMEDIATE CAUSE (a) <u>RESPIRATORY ARREST</u>
DUE TO, OR AS A CONSEQUENCE OF (b) <u>END STAGE CANCER METASTASIS</u>
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last } DUE TO, OR AS A CONSEQUENCE OF (c) <u>FROM COLON</u> | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) | | | | | | | | | |
| 19a DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. <u>19</u> | | 21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) | | | | | |
| 21d INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21e PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f LOCATION STREET CITY OR TOWN COUNTY STATE | | | | | |
| 22a I certify that (I) (this hospital) attended the deceased from <u>FEB. 5</u> , 19 <u>82</u> to <u>FEB. 11</u> , 19 <u>82</u> that (I) (we) last saw the deceased alive on <u>FEB. 10</u> , 19 <u>82</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above (I) (we) (did) (did not) view the body after death. | | | | | | | | | |
| 22b SIGNATURE <u>Wm. Hugo C. Davis, MD</u> | | | | DEGREE | | ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> | | 22c DATE SIGNED <u>2/11/82</u> | |
| 22d PHYSICIAN'S NAME (TYPE OR PRINT) <u>DAVIS</u> | | | | 22e ADDRESS <u>J.L. DEATON CENTER, BALT., MD. 21230</u> | | | | | |
| 23a BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u> | | 23b DATE <u>Feb. 13, 1982</u> | | 23c NAME OF CEMETERY OR CREMATORY <u>Woodlawn</u> | | 23d LOCATION CITY OR TOWN COUNTY STATE <u>Baltimore Balto. Md.</u> | | | |
| 24 FUNERAL DIRECTOR NAME <u>Leonard J. Ruck Inc. Baltimore, Maryland</u> | | | | 25a DATE REC'D. BY REGISTRAR <u>FEB 16 1982</u> | | 25b REGISTRAR'S SIGNATURE <u>Thom J. North</u> | | | |

BP

1870

1871

1872

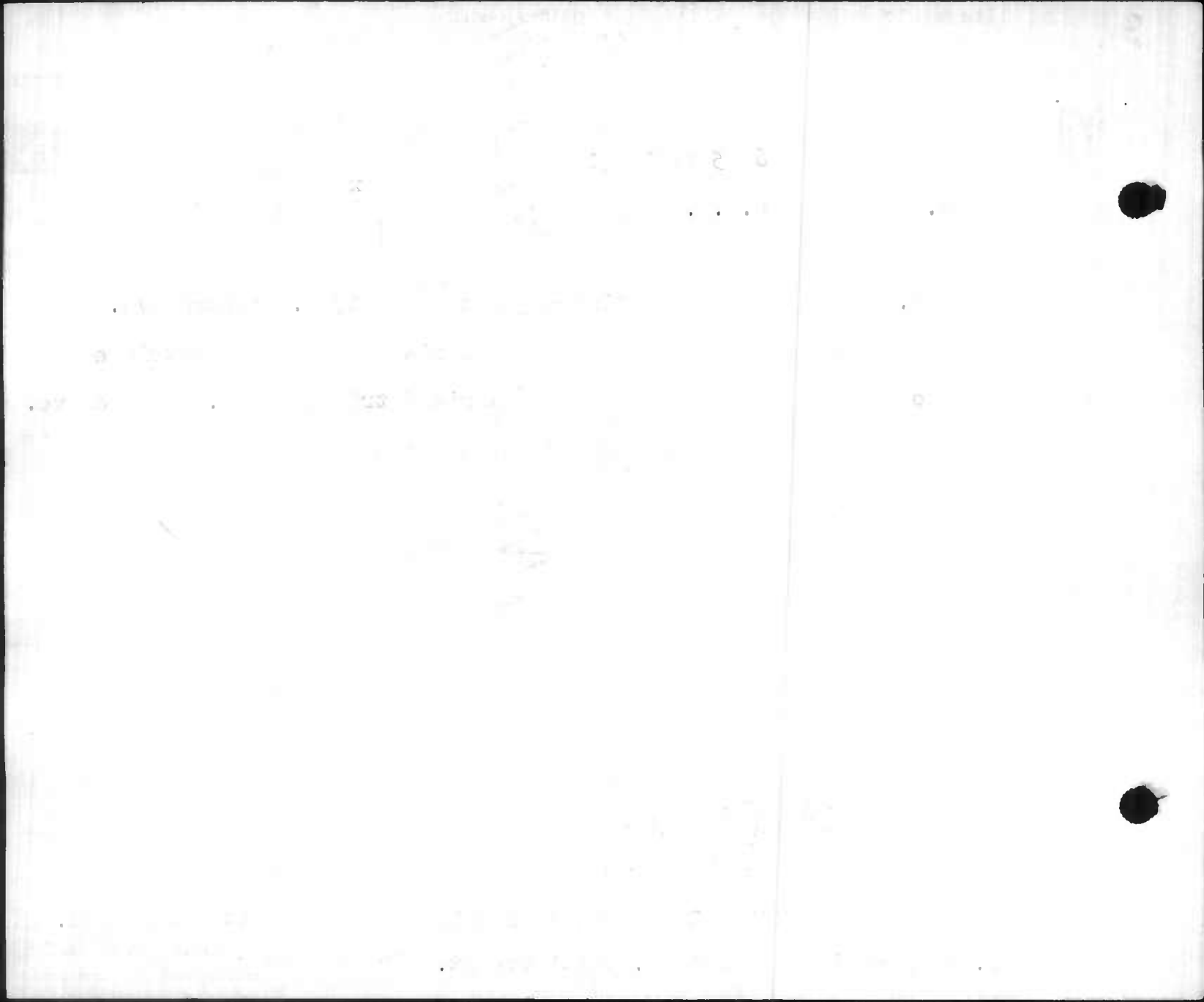
TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL HOME. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITH PAGES 3 AND 4, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

Items 21c & 22a G565 3/26/82

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

| | | | | | |
|--|--|--|--|---|--|
| 1. FOR
STATE
REGISTRAR | | dad | | 5 2 0 3 / 8 5 | |
| 1. DECEASED NAME
(TYPE OR PRINT) | | | | 2a. DATE KNOWN
OF
DEATH | |
| DENVER | | | | 2b. DATE KNOWN
OF
DEATH | |
| 3. SEX | | | | 2c. DATE
PRONOUNCED
DEAD | |
| male | | | | 2d. HOUR
2:30 | |
| 4. RACE | | 5. DATE OF BIRTH | | 6. AGE (IN YEARS) | |
| white | | 6 5 1962 | | 19 YRS. | |
| 7a. BIRTHPLACE (STATE OR
FOREIGN COUNTRY) | | 7b. CITIZEN OF WHAT COUNTRY? | | 8. MARRIED | |
| Md. | | U.S.A. | | NEVER MARRIED <input checked="" type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | |
| 9. BALTIMORE CITY OR COUNTY OF DEATH | | 10. CITY OR TOWN OF DEATH | | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION | |
| Baltimore City | | Baltimore | | University Hospital | |
| 12a. USUAL OCCUPATION (TYPE OF WORK
FOR MOST OF WORKING LIFE) | | 12b. KIND OF BUSINESS
OR INDUSTRY | | 13a. STATE | |
| | | | | Md. | |
| 13b. COUNTY | | 13c. CITY OR TOWN | | 13d. INSIDE CITY LIMITS? | |
| | | Baltimore | | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 13e. STREET ADDRESS | | 14. FATHER'S NAME | | 15. MOTHER'S MAIDEN NAME | |
| 119 N. Belnord Ave. | | Unknown | | Marie Guttridge | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO, OR UNKNOWN) | | 16b. SOCIAL SECURITY NO. | | 17. INFORMANT | |
| No | | | | Marie Guttridge 119 N. Belnord Ave. | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) | | | | | |
| PART I DEATH WAS CAUSED BY: | | | | | |
| IMMEDIATE CAUSE (a) Closed head trauma with complications | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF | | | | | |
| (b) | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF | | | | | |
| (c) | | | | | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | | 20. AUTOPSY? | |
| | | | | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 21a. EXTERNAL CAUSE WAS | | 21b. TIME OF INJURY | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) | |
| UNDERLYING <input checked="" type="checkbox"/> OR
CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH | | ? P.M. 9-20- 1981 | | Subject was assaulted. Fell from bench | |
| 21d. INJURY OCCURRED | | 21e. PLACE OF INJURY (AT HOME,
STREET, FACTORY, FARM, ETC.) | | 21f. LOCATION | |
| WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/>
AT WORK AT WORK | | park | | Patterson Park Balto. Md. | |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion | | | | | |
| death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> | | | | | |
| ACTUAL
SIGNATURE | | M.D. Assistant | | DATE
SIGNED | |
| Ann M. Dixon, M.D. | | 111 Penn St. | | 2-12-82 | |
| EXAMINER'S NAME
(TYPE OR PRINT) | | ADDRESS | | 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY) | |
| | | | | Burial | |
| 23b. DATE | | 23c. NAME OF CEMETERY OR CREMATORY | | 23d. LOCATION | |
| 2/17/82 | | Gardens of Faith | | Baltimore Md. | |
| 24. FUNERAL DIRECTOR
NAME | | ADDRESS | | 25a. DATE REC'D. BY REGISTRAR | |
| B. Dabrowski & Son | | 2818 E. Baltimore St. | | FEB 18 1982 | |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

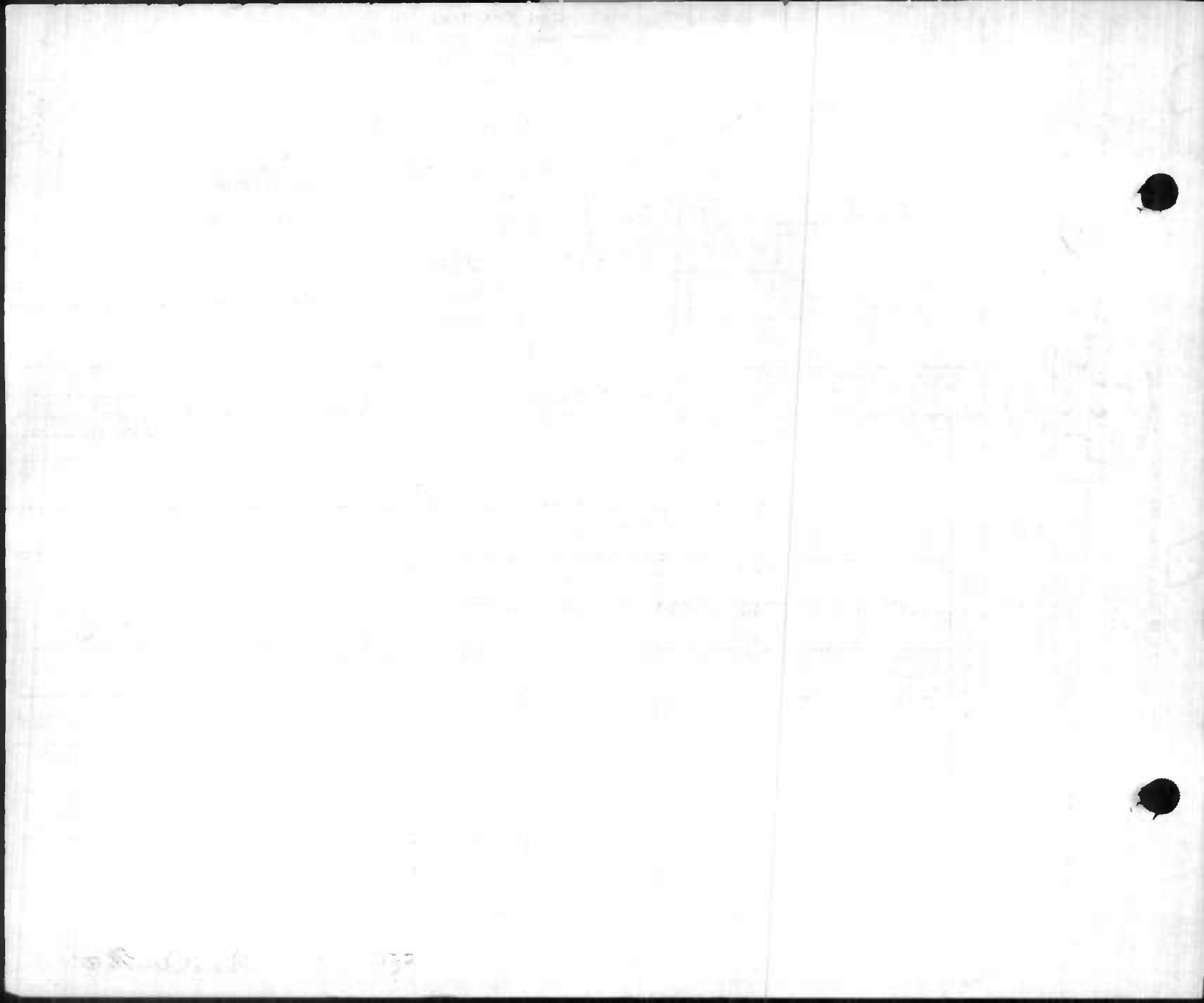
STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 2, 0 3 / 8 6

REG. NO.

1. FOR
STATE
REGISTRAR

| | | | | | | | |
|---|--|---|--|---|----------------------------|--|--|
| 1. DECEASED NAME
(TYPE OR PRINT)
FIRST MIDDLE LAST
EDWARD C. HAAS, SR. | | | 2a. DATE OF DEATH
MONTH DAY YEAR
2 3 82 | | 2b. HOUR
2:15 PM | | |
| 3. SEX
Male | | 4. RACE
White | | 5. DATE OF BIRTH
MONTH DAY YEAR
07 7 29 | | 6. AGE (IN YEARS LAST BIRTHDAY)
YRS MONTHS DAYS
52 7 7 | |
| 7. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
Md. | | 7b. CITIZEN OF WHAT COUNTRY?
USA. | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
CITY MD. | |
| 10. CITY OR TOWN OF DEATH
Baltimore | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
SINAI HOSP. | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
Truck Driver | | 12b. KIND OF BUSINESS OR INDUSTRY
Sun Papers | |
| 13a. STATE
Md. | | 13b. CITY OR TOWN
Baltimore | | 13c. INSIDE CITY LIMITS?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 13d. STREET ADDRESS
7502 LAWRENCE RD. | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
Not Known | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
Anna Haas | | 16. ADDRESS
7502 Lawrence Rd. Balto., MD. 21222 | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
Yes | | 16b. SOCIAL SECURITY NO.
(IF YES, GIVE WAR OR DATES)
WW II | | 17. INFORMANT
Edward C. Haas, Jr. | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) ASCVD
2500
DUE TO, OR AS A CONSEQUENCE OF
(b) diabetes mellitus, 2 end-stage renal dis
DUE TO, OR AS A CONSEQUENCE OF
(c) | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) | | | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK AT WORK | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 1/6 , 19 82 , to 2/3 , 19 82 , that (I) (we) lost
saw the deceased alive on 2/3 , 19 82 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated
above, (I) (we) (did) (did not) view the body after death. | | | | | | | |
| 22b. SIGNATURE
John Gordon | | DEGREE
M.D. | | ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> | | 22c. DATE SIGNED
2/3/82 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
JOHN GORDON MD | | 22e. ADDRESS
SINAI Hosp. | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)
Burial | | 23b. DATE
2/6/1982 | | 23c. NAME OF CEMETERY OR CREMATORY
Holly Hill | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
White Marsh Maryland | |
| 24. FUNERAL DIRECTOR
NAME
Duda-Ruck, Inc | | | | ADDRESS
7922 Wise Avenue Dundalk, MD. 21222 | | 25a. DATE REC'D. BY REGISTRAR
FEB 4 1982 | |
| | | 25b. REGISTRAR'S SIGNATURE
James J. North | | | | | |



STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

2 03 / 87

1- FOR
STATE
REGISTRAR

REG. NO.

| | | | | | | |
|---|--|---|--|---|----------------------------|---|
| 1. DECEASED NAME
(TYPE OR PRINT)
FIRST MIDDLE LAST
Florence E. Hablick | | | 2a. DATE OF DEATH
MONTH DAY YEAR
February 13 1982 | | 2b. HOUR
10:00am | |
| 3. SEX
Female | | 4. RACE
White | | 5. DATE OF BIRTH
MONTH DAY YEAR
Dec. 15, 1905 | | 6. AGE
(IN YEARS LAST BIRTHDAY)
76 YRS |
| 7a. BIRTHPLACE
(STATE OR FOREIGN COUNTRY)
Maine | | 7b. CITIZEN OF WHAT COUNTRY?
USA | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
Baltimore City MD. |
| 10. CITY OR TOWN OF DEATH
Baltimore | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
Maryland General Hospital | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
Nurse | | 12b. KIND OF BUSINESS OR INDUSTRY
Nursing |
| 13a. STATE
Maryland | | 13b. COUNTY
Baltimore | | 13c. CITY OR TOWN
Baltimore | | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
Samuel D. McCormick | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
Eve Littlefield | | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
No | | |
| 16b. SOCIAL SECURITY NO.
220 46 7114 | | 17. INFORMANT
Mr. Frank J. Hablick, | | ADDRESS
Same | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART 1. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Cardiovascular Collapse
4292
DUE TO, OR AS A CONSEQUENCE OF
(b) Severe Atherosclerotic Cardiovascular Disease
and right Cerebrovascular Accident
DUE TO, OR AS A CONSEQUENCE OF
(c) with Extension of Cerebral Infarct times 2 | | | | | | APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATH |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:
Status Post Sepsis with Streptococcus Viridans | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED
IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> AT WORK
NOT WHILE <input type="checkbox"/> AT WORK | | 21e. PLACE OF INJURY
(AT HOME STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | |
| 22a. I certify that (X) (this hospital) attended the deceased from December 1, 1981 , to February 13, 1982 , that (X) (we) lost
saw the deceased alive on February 13, 1982 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated
above, (I) (we) (did) (did not) view the body after death. | | | | | | |
| 22b. SIGNATURE
Michael A. Hyle MD | | | | DEGREE
MD | | 22c. DATE SIGNED
2/13/82 |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
Michael A. Hyle, M. D. | | | | 22e. ADDRESS
c/o Maryland General Hospital | | |
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)
Burial | | 23b. DATE
2/16/82 | | 23c. NAME OF CEMETERY OR CREMATORY
Parkwood | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
Balto., County, Md. |
| 24. FUNERAL DIRECTOR
NAME
Henry W. Jenkins & Sons Co. | | | | 25a. DATE REC'D. BY REGISTRAR
FEB 16 1982 | | 25b. REGISTRAR'S SIGNATURE
Thomas J. North |
| 4905 York Road Balto., Md. 21212 | | | | | | |

Don J

In

Belgium

Belgium

James D.

No

One to 2114 E. 4th, Washington, D.C.

Cardinal College

Seven 22nd Street, Washington, D.C.

in the city of Washington, D.C.

Washington, D.C. 20004

Page 11

Washington, D.C. 20004

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Washington, D.C. 20004

Washington, D.C. 20004

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

9 2 0 3 / 8 8

1- FOR
STATE
REGISTRAR

REG. NO.

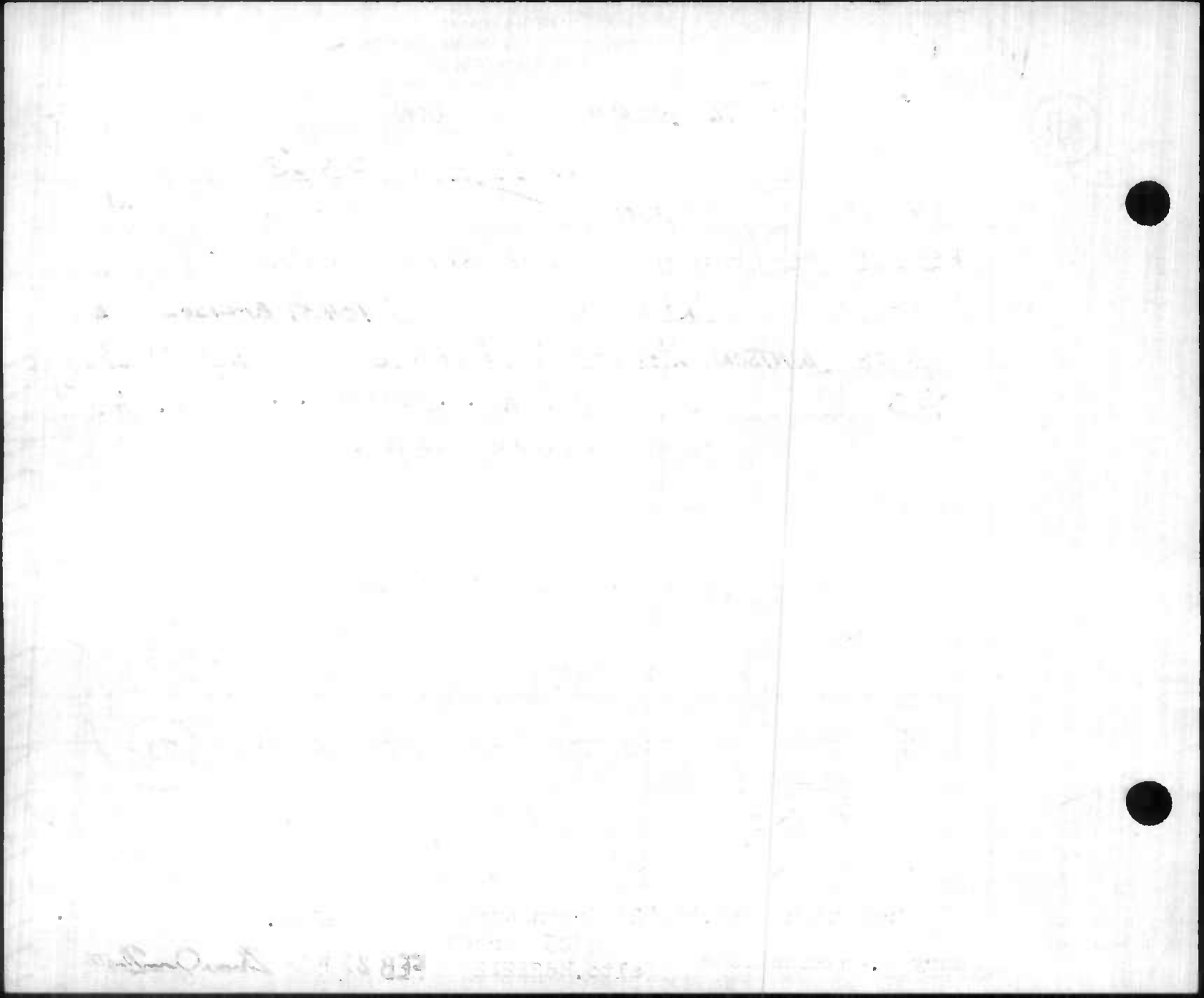
| | | | | | | | | | |
|---|--|---|--|---|--|--|--|---|--|
| 1. DECEASED NAME
(TYPE OR PRINT) WELLFORD NORVAN HADDON | | | 2a. DATE OF DEATH
MONTH 2 DAY 18 YEAR 82 | | | 2b. HOUR
11 50 P.M. | | | |
| 3. SEX
M | | 4. RACE
W | | 5. DATE OF BIRTH
MONTH 12 DAY 16 YEAR 28 | | 6. AGE (IN YEARS LAST BIRTHDAY)
53 YRS. | | IF UNDER 1 YEAR
MONTHS DAYS HOURS MIN. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN)
VA. | | 7b. CITIZEN OF WHAT COUNTRY?
USA | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
BALTO CITY MD | | | |
| 10. CITY OR TOWN OF DEATH
BALTO. | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
UNIVERSITY HOSPITAL | | | | 12a. USUAL OCCUPATION
(TYPE) ARTIST | | 12b. KIND OF BUSINESS OR INDUSTRY | |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE A.D.)
VA. | | 13b. COUNTY
RICHMOND | | 13c. INSIDE CITY LIMITS?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS
10451 EPLISON RD. | | | |
| 14. FATHER'S NAME
HUGH WATSON HADDON | | | | 15. MOTHER'S MAIDEN NAME
ANNIE HENDRICK | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN) YES | | 16b. SOCIAL SECURITY NO.
227-30-7006 | | 17. INFORMANT
ADDRESS RICHMOND, VA.
A.W. BENNETT CO. | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) PSEUDOMONAS SEPTIS
2000
DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b) _____
DUE TO, OR AS A CONSEQUENCE OF
(c) _____
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH (NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I.)
Diffuse histiocytic lymphoma | | | | | | | | | |
| 19a. DATE OF OPERATION
NA | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) | | | | | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
(STREET) CITY OR TOWN COUNTY STATE | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 2-13-1982 to 2-18-1982 that (I) (we) lost
saw the deceased alive on 2-18-1982 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated
above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | |
| 22b. SIGNATURE
Wendy D. Reddy | | | | DEGREE MD ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | | | 22c. DATE SIGNED
2-18-82 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
Wendy D. Reddy | | | | 22e. ADDRESS
UMCC, 22 S Greene St
Baltimore - Md 21201 | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY) Cremation | | 23b. DATE
Feb. 20, 82 | | 23c. NAME OF CEMETERY OR CREMATORY
GreenMount | | 23d. LOCATION
CITY OR TOWN Balto. COUNTY Md. | | | |
| 24. FUNERAL DIRECTOR
NAME Henry W. Jenkins & Sons ADDRESS 4905 York Rd
Balto. Md 21212 | | | | 25a. DATE REC'D. BY REGISTRAR
FEB 23 1982 | | 25b. REGISTRAR'S SIGNATURE
Thomas J. North | | | |

BP

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 2 and 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.



BP

DHMH-1650M 1/81
(VRA 15, 4)

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. It may be retained by the hospital or attending physician and completely filled in by the funeral director on page 3 of this certificate. The remainder of the certificate should be detached for use as the burial-transit permit and should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director on page 3 of this certificate, the remainder of the certificate should be detached for use as the burial-transit permit and should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH | | | | | | | | | | REG. NO. | |
|--|--|--|--|--|--|---|--|--|--|---|--|
| 1. FOR STATE REGISTRAR | | 1. DECEASED NAME (TYPE OR PRINT)
FIRST MIDDLE LAST
Jeanne D Hagenow | | | | | | 2a. DATE OF DEATH
MONTH DAY YEAR
2-9-82 | | 2b. HOUR
6:52P | |
| 3 SEX
Female | | 4 RACE
White | | 5. DATE OF BIRTH
MONTH DAY YEAR
Feb 7 1927 | | 6 AGE (IN YEARS LAST BIRTHDAY)
55 YRS. | | IF UNDER 1 YEAR
MONTHS DAYS | | IF UNDER 24 HRS.
HOURS MIN. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
ILLINOIS | | 7b. CITIZEN OF WHAT COUNTRY?
U.S.A. | | 8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9 BALTIMORE CITY OR COUNTY OF DEATH
Baltimore City MD. | | | | | |
| 10. CITY OR TOWN OF DEATH | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
Johns Hopkins Hospital | | | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)
Clerical Adjuster | | 12b. KIND OF BUSINESS OR INDUSTRY
Insurance | |
| 13a. STATE
Penn | | 13b. COUNTY
York | | 13c. CITY OR TOWN
York | | 13d. INSIDE CITY LIMITS?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 13e. STREET ADDRESS
3215 Lynwood Lane | | | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
Uncertainable | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
Margaret Irwin | | | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)
No | | 16b. SOCIAL SECURITY NO.
355-18-2767 | | 17. INFORMANT ADDRESS
Donald Hagenow York, Penna | | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART 1. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) 4160
DUE TO, OR AS A CONSEQUENCE OF (b) PULMONARY HYPERTENSION
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO, OR AS A CONSEQUENCE OF (c) | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
8 HOURS
10 YEARS | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a):
GASTROINTESTINAL BLEEDING | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) | | | | | | | |
| 21d. INJURY OCCURRED
WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY
(AT HOME STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 2/9 1982, to 2/9 1982, that (I) (we) lost view of the deceased alive on 2/9 1982, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death. | | | | | | | | | | | |
| 22b. SIGNATURE
Eric J. Seifter | | | | DEGREE
MD | | | | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | 22c. DATE SIGNED
2/9/82 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
ERIC J. SEIFTER | | | | 22e. ADDRESS
JOHNS HOPKINS HOSPITAL | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)
Cremation | | 23b. DATE
2-11-1982 | | 23c. NAME OF CEMETERY OR CREMATORY
York Crematory | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
Columbia Lancaster Pa. | | | | | |
| 24. FUNERAL DIRECTOR
NAME
Mitchell-Windel, Inc. Baltimore, Md. | | | | 25a. DATE REC'D. BY REGISTRAR
FEB 19 1982 | | 25b. REGISTRAR'S SIGNATURE
Thom J. Galloway | | | | | |

1. The first part of the document is a letter from the President of the United States to the Secretary of the Navy, dated 18th March 1881. The letter is signed by the President and is addressed to the Secretary of the Navy.

2. The second part of the document is a letter from the Secretary of the Navy to the President, dated 18th March 1881. The letter is signed by the Secretary of the Navy and is addressed to the President.

3. The third part of the document is a letter from the Secretary of the Navy to the President, dated 18th March 1881. The letter is signed by the Secretary of the Navy and is addressed to the President.

4. The fourth part of the document is a letter from the Secretary of the Navy to the President, dated 18th March 1881. The letter is signed by the Secretary of the Navy and is addressed to the President.

5. The fifth part of the document is a letter from the Secretary of the Navy to the President, dated 18th March 1881. The letter is signed by the Secretary of the Navy and is addressed to the President.

6. The sixth part of the document is a letter from the Secretary of the Navy to the President, dated 18th March 1881. The letter is signed by the Secretary of the Navy and is addressed to the President.

7. The seventh part of the document is a letter from the Secretary of the Navy to the President, dated 18th March 1881. The letter is signed by the Secretary of the Navy and is addressed to the President.

8. The eighth part of the document is a letter from the Secretary of the Navy to the President, dated 18th March 1881. The letter is signed by the Secretary of the Navy and is addressed to the President.

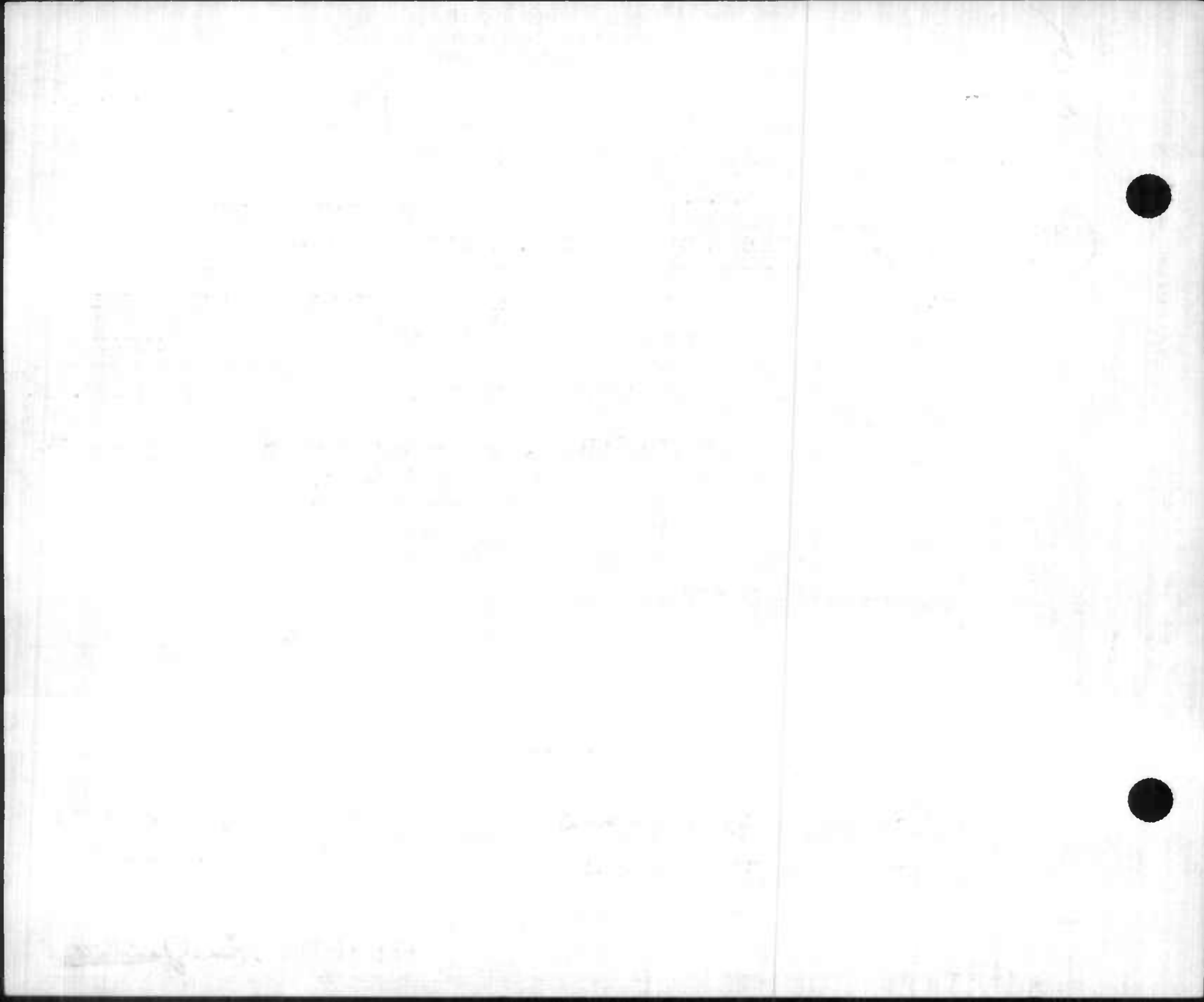
9. The ninth part of the document is a letter from the Secretary of the Navy to the President, dated 18th March 1881. The letter is signed by the Secretary of the Navy and is addressed to the President.

10. The tenth part of the document is a letter from the Secretary of the Navy to the President, dated 18th March 1881. The letter is signed by the Secretary of the Navy and is addressed to the President.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be retained by the funeral director. Page 3 should be retained by the funeral director. Page 4 should be retained by the funeral director. Page 5 should be retained by the funeral director. Page 6 should be retained by the funeral director. Page 7 should be retained by the funeral director. Page 8 should be retained by the funeral director. Page 9 should be retained by the funeral director. Page 10 should be retained by the funeral director. Page 11 should be retained by the funeral director. Page 12 should be retained by the funeral director. Page 13 should be retained by the funeral director. Page 14 should be retained by the funeral director. Page 15 should be retained by the funeral director. Page 16 should be retained by the funeral director. Page 17 should be retained by the funeral director. Page 18 should be retained by the funeral director. Page 19 should be retained by the funeral director. Page 20 should be retained by the funeral director. Page 21 should be retained by the funeral director. Page 22 should be retained by the funeral director. Page 23 should be retained by the funeral director. Page 24 should be retained by the funeral director. Page 25 should be retained by the funeral director. Page 26 should be retained by the funeral director. Page 27 should be retained by the funeral director. Page 28 should be retained by the funeral director. Page 29 should be retained by the funeral director. Page 30 should be retained by the funeral director. Page 31 should be retained by the funeral director. Page 32 should be retained by the funeral director. Page 33 should be retained by the funeral director. Page 34 should be retained by the funeral director. Page 35 should be retained by the funeral director. Page 36 should be retained by the funeral director. Page 37 should be retained by the funeral director. Page 38 should be retained by the funeral director. Page 39 should be retained by the funeral director. Page 40 should be retained by the funeral director. Page 41 should be retained by the funeral director. Page 42 should be retained by the funeral director. Page 43 should be retained by the funeral director. Page 44 should be retained by the funeral director. Page 45 should be retained by the funeral director. Page 46 should be retained by the funeral director. Page 47 should be retained by the funeral director. Page 48 should be retained by the funeral director. Page 49 should be retained by the funeral director. Page 50 should be retained by the funeral director. Page 51 should be retained by the funeral director. Page 52 should be retained by the funeral director. Page 53 should be retained by the funeral director. Page 54 should be retained by the funeral director. Page 55 should be retained by the funeral director. Page 56 should be retained by the funeral director. Page 57 should be retained by the funeral director. Page 58 should be retained by the funeral director. Page 59 should be retained by the funeral director. Page 60 should be retained by the funeral director. Page 61 should be retained by the funeral director. Page 62 should be retained by the funeral director. Page 63 should be retained by the funeral director. Page 64 should be retained by the funeral director. Page 65 should be retained by the funeral director. Page 66 should be retained by the funeral director. Page 67 should be retained by the funeral director. Page 68 should be retained by the funeral director. Page 69 should be retained by the funeral director. Page 70 should be retained by the funeral director. Page 71 should be retained by the funeral director. Page 72 should be retained by the funeral director. Page 73 should be retained by the funeral director. Page 74 should be retained by the funeral director. Page 75 should be retained by the funeral director. Page 76 should be retained by the funeral director. Page 77 should be retained by the funeral director. Page 78 should be retained by the funeral director. Page 79 should be retained by the funeral director. Page 80 should be retained by the funeral director. Page 81 should be retained by the funeral director. Page 82 should be retained by the funeral director. Page 83 should be retained by the funeral director. Page 84 should be retained by the funeral director. Page 85 should be retained by the funeral director. Page 86 should be retained by the funeral director. Page 87 should be retained by the funeral director. Page 88 should be retained by the funeral director. Page 89 should be retained by the funeral director. Page 90 should be retained by the funeral director. Page 91 should be retained by the funeral director. Page 92 should be retained by the funeral director. Page 93 should be retained by the funeral director. Page 94 should be retained by the funeral director. Page 95 should be retained by the funeral director. Page 96 should be retained by the funeral director. Page 97 should be retained by the funeral director. Page 98 should be retained by the funeral director. Page 99 should be retained by the funeral director. Page 100 should be retained by the funeral director.

| STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH | | | | 8 2 0 3 7 9 0 | | | |
|--|--|--|--|---|--|--|--|
| 1 - FOR STATE REGISTRAR | | | | REG. NO. | | | |
| 1 DECEASED NAME (TYPE OR PRINT)
FIRST MIDDLE LAST
HOWARD W. HALL | | | | 2a. DATE OF DEATH
MONTH DAY YEAR
FEB. 9 82 | | 2b. HOUR
7:45A M | |
| 3 SEX
MALE | | 4 RACE
BLACK | | 5. DATE OF BIRTH
MONTH DAY YEAR
9 22 08 | | 6 AGE (IN YEARS (LAST BIRTHDAY))
73 | |
| 7a. BIRTHPLACE (STATE OR FOREIGN)
MARYLAND | | 7b. CITIZEN OF WHAT COUNTRY?
U.S.A. | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/> | | 9 BALTIMORE CITY OR COUNTY OF DEATH
BALTIMORE CITY MD. | |
| 10. CITY OR TOWN OF DEATH
BALTIMORE, | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
VAMC, LOCH RAVEN BALTO. MD 21218 | | | | 12a. USUAL OCCUPATION
(TYPE OF WORK (FOR MOST OF WORKING LIFE))
MECHANIC | |
| 12b. KIND OF BUSINESS OR INDUSTRY | | 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)
13a. STATE
MARYLAND | | 13b. COUNTY | | 13c. CITY OR TOWN
BALTIMORE | |
| 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS
3103 LEIGHTON AVE | | 13f. CITY OR TOWN
BALTIMORE | | 13g. STATE
MD. | |
| 14. FATHER'S NAME
BENJAMIN | | 15. MOTHER'S MAIDEN NAME
EIMONIA DAILEY | | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
YES (NO OR UNKNOWN) WWII | | | |
| 16b. SOCIAL SECURITY NO.
213 01 6268 | | 17. INFORMANT
Effie Hall ADDRESS 3103 Leighton Ave
MEDICAL RECORDS VAMC, LOCH RAVEN BALTO. MD. | | | | | |
| 18 CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c).
PART 1. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>metastatic squamous cell cancer of</u>
1629 <u>right lung</u>
DUE TO, OR AS A CONSEQUENCE OF (b) _____
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO, OR AS A CONSEQUENCE OF (c) _____
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
5 months | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a:
<u>none</u> | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | |
| 21d. INJURY OCCURRED
WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | |
| 22a. I certify that the this hospital attended the deceased from <u>FEBRUARY 4</u> , 19 <u>82</u> , to <u>FEBRUARY 9</u> , 19 <u>82</u> . that (s/he) (we) last saw the deceased alive on <u>FEBRUARY 9</u> , 19 <u>82</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I/we) (did) (not) view the body after death. | | | | | | | |
| 22b. SIGNATURE
<u>Howard Jacobs MD</u> | | DEGREE | | ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> | | 22c. DATE SIGNED
2/9/82 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
HOWARD JACOBS MD | | 22e. ADDRESS
3900 LOCH RAVEN BLVD. BALTO. MD. 21218 | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)
Burial | | 23b. DATE
2/13/82 | | 23c. NAME OF CEMETERY OR CREMATORY
Arbutus Mem. Pk. | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
Baltimore Co. MD | |
| 24. FUNERAL DIRECTOR
NAME
Wm. C. March F/H | | ADDRESS
1101 E. North Ave. | | 25a. DATE REC'D BY REGISTRAR
FEB 10 1982 | | 25b. REGISTRAR'S SIGNATURE
<u>James J. [Signature]</u> | |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Burial/cremation be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 24 hours of death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1 - FOR
STATE
REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 2 0 3 7 9 1

REG. NO.

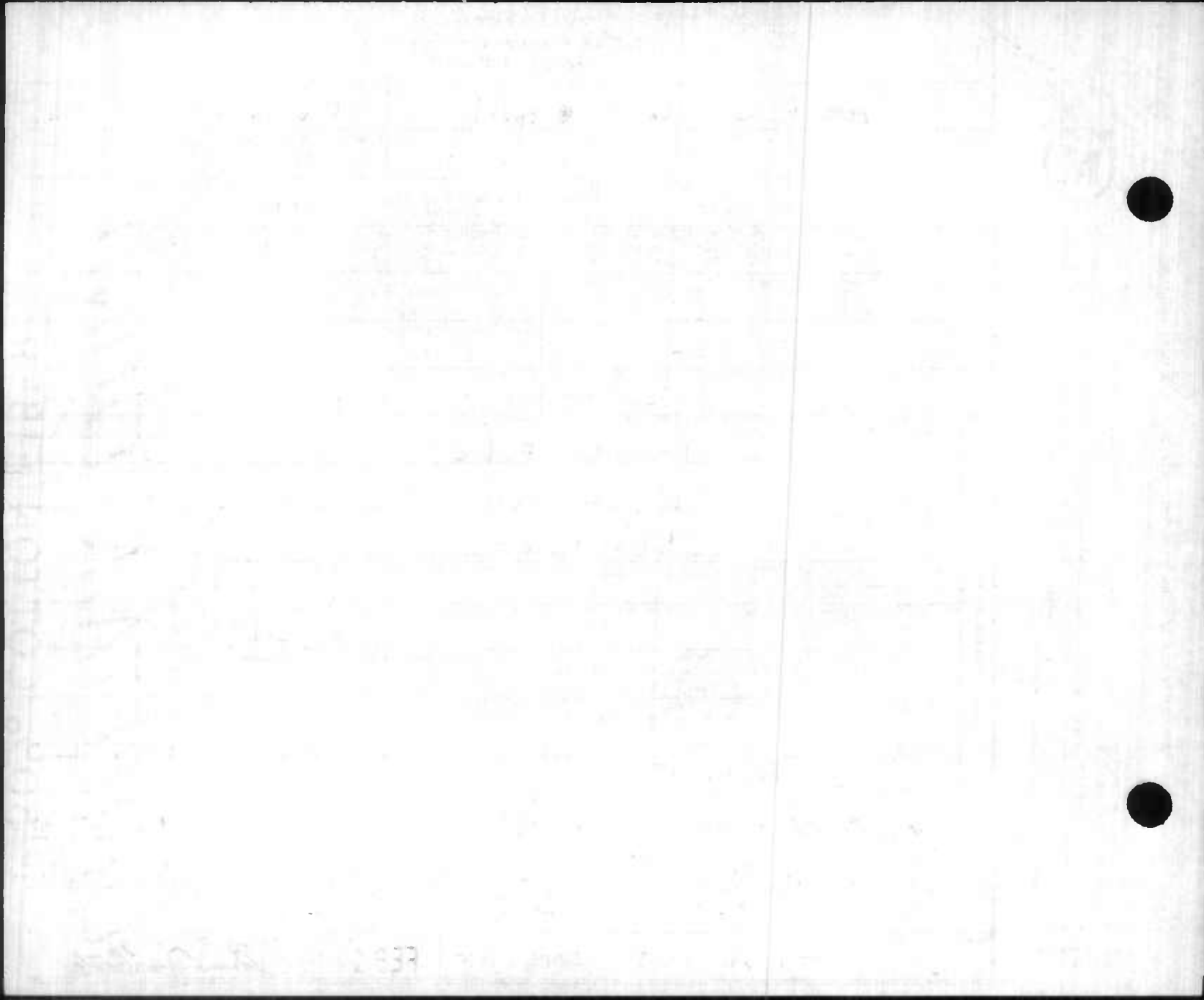
| | | | | | | |
|--|--|--|--|--|--|--|
| 1. DECEASED NAME
(TYPE OR PRINT) Rose C. Hall | | | 2a. DATE OF DEATH
MONTH DAY YEAR
Feb 14, 1982 | | 2b. HOUR
6¹⁰ A.M. | |
| 3. SEX
Female | | 4. RACE
Black | | 5. DATE OF BIRTH
MONTH DAY YEAR
12 4 16 | | |
| 6. AGE (IN YEARS LAST BIRTHDAY)
65 | | 7. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
MD | | 8. CITIZEN OF WHAT COUNTRY?
USA | | |
| 9. BALTIMORE CITY OR COUNTY OF DEATH
Baltimore City | | 10. CITY OR TOWN OF DEATH
Baltimore | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
1331 N. Ellwood Avenue | | |
| 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE) | | 12b. KIND OF BUSINESS OR INDUSTRY | | 13. STREET ADDRESS
1331 N. Ellwood Avenue | | |
| 13a. STATE
MD | | 13b. COUNTY | | 13c. CITY OR TOWN
Baltimore | | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
John Carrington | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
Elizabeth Braden | | 16. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)
No | | |
| 17. INFORMANT
ADDRESS
William Hall 1331 N. Ellwood Avenue | | 18a. SOCIAL SECURITY NO.
217-09-5523 | | 18b. DATE OF OPERATION | | |

| | | |
|---|--|--|
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART 1. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Respiratory Failure
1749
DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b) lung metastases
DUE TO, OR AS A CONSEQUENCE OF
(c) Breast Cancer | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
3 mo
7 mo
2 1/2 years |
|---|--|--|

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)

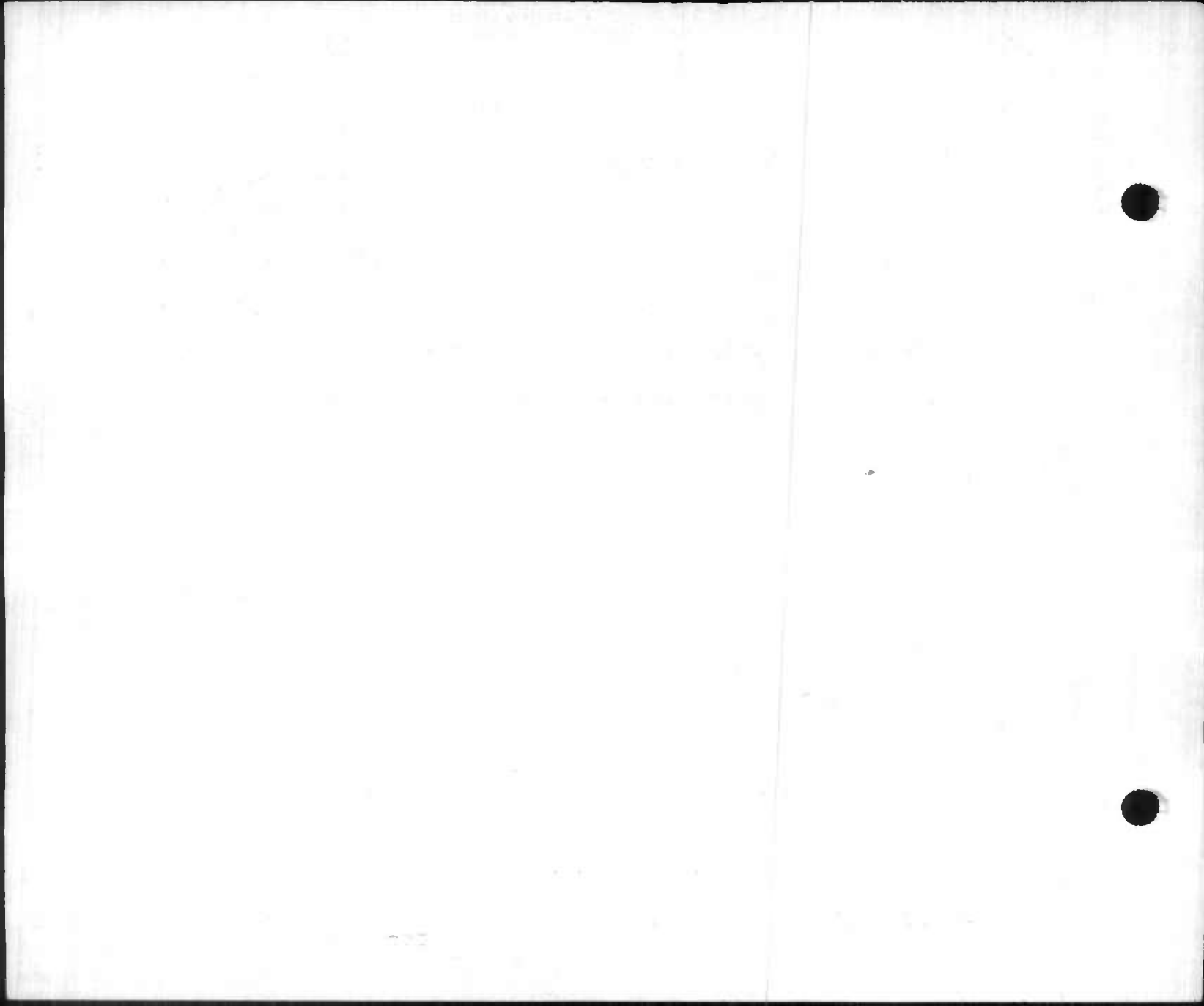
| | | | | | | | |
|---|--|--|--|--|--|--|--|
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> AT WORK OR NOT WHILE <input type="checkbox"/> AT WORK | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from July , 19 81 , to February , 19 82 , that (I) first lost saw the deceased alive on February 9th , 19 82 , and that in (my) own opinion death occurred on the date and hour and from the causes stated above. (I) did not view the body after death. | | | | | | | |
| 22b. SIGNATURE
Scott D. Rowley, M.D. | | | | DEGREE
M.D. | | 22c. DATE SIGNED
Feb. 16th 1982 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
Scott D. Rowley, M.D. | | | | 22e. ADDRESS
Johns Hopkins Hospital Oncology Center Baltimore | | | |

| | | | | | | | |
|--|--|-----------------------------|--|---|--|---|--|
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)
Burial | | 23b. DATE
2/18/82 | | 23c. NAME OF CEMETERY OR CREMATORY
Md. Veteran Cem. | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
Crownsville MD | |
| 24. FUNERAL DIRECTOR
NAME
Win. C. March F/H | | | | 1101 E. North Ave. | | 25a. DATE REC'D. BY REGISTRAR
FEB 17 1982 | |
| | | | | 25b. REGISTRAR'S SIGNATURE
James J. [Signature] | | | |



TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE FORMS 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PW 3. RETAIN PAGE 5 IN YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 2 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

| STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH | | | | | | | | | | REG. NO. 2 0 3 7 9 2 | |
|---|--|--|--|--|--|---|--|---|--|---|--|
| 1. FOR STATE REGISTRAR | | | | | | | | | | | |
| 1. DECEASED NAME
(TYPE OR PRINT) FIRST MIDDLE LAST
Bernard Hamlet | | | | | | 2b. DATE KNOWN OF DEATH
XX MONTH DAY YEAR
2 3 19 82 | | 2c. DATE OF DEATH
MONTH DAY YEAR
2 3 19 82 | | 2d. HOUR
M
9:45 a.m. | |
| 3. SEX
Male | | 4. RACE
Black | | 5. DATE OF BIRTH
MONTH DAY YEAR
Oct. 13 1934 | | 6. AGE (IN YEARS)
(LAST BIRTHDAY) YRS.
47 | | 7. IF UNDER 1 YR.
MONTHS DAYS
IF UNDER 24 HRS.
HOURS MIN. | | 7c. DATE PRONOUNCED DEAD
MONTH DAY YEAR
2 3 19 82 | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
Virginia | | 7b. CITIZEN OF WHAT COUNTRY?
U.S.A. | | | | 8. MARRIED
<input checked="" type="checkbox"/> NEVER MARRIED
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
Baltimore City, MD | | | |
| 10. CITY OR TOWN OF DEATH
Baltimore | | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
1667 Darley Avenue | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)
Unemployed | | 12b. KIND OF BUSINESS OR INDUSTRY | | | |
| USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) | | | | | | 13a. STATE
Md. | | 13b. COUNTY | | 13c. CITY OR TOWN
Balto. | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
JOHN HAMLETT | | | | | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
SALLIE CROWDER | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO, OR UNKNOWN)
Yes | | | | | | 16b. SOCIAL SECURITY NO.
1953-1955 225-46-0824 | | 17. INFORMANT
ADDRESS
VELERIA TAYLOR 1541 Tunlaw Rd. | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I DEATH WAS CAUSED BY:
9889 IMMEDIATE CAUSE (a) Seizure Disorder
Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last:
(b) DUE TO, OR AS A CONSEQUENCE OF
(c) DUE TO, OR AS A CONSEQUENCE OF | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)
Arteriosclerotic Cardiovascular Disease and old brain contusions | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | | | | 20. AUTOPSY?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | |
| 21a. EXTERNAL CAUSE WAS
UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
21d. INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/> | | | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
? P.M. ? 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)
? | | | | | |
| 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)
? | | | | 21f. LOCATION
STREET
? | | CITY OR TOWN | | COUNTY | | STATE | |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input checked="" type="checkbox"/> . | | | | | | | | | | | |
| ACTUAL SIGNATURE
Virginia L. Dolan | | | | | | TITLE (SPECIFY)
Assistant | | MEDICAL EXAMINER | | DATE SIGNED
2-3-82 | |
| EXAMINER'S NAME
(TYPE OR PRINT)
Virginia L. Dolan, M.D. | | | | | | ADDRESS
111 Penn Street | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)
Burial | | | | 23b. DATE
2-9-82 | | 23c. NAME OF CEMETERY OR CREMATORY
Crownsville Vet. Cem. | | | | 23d. LOCATION
CITY OR TOWN
Annapolis County Md. | |
| 24. FUNERAL DIRECTOR
NAME
CALVIN B. SCRUGGS | | | | | | ADDRESS
1412 E. Preston St. | | 25a. DATE REC'D. BY REGISTRAR
FEB 5 1982 | | | |

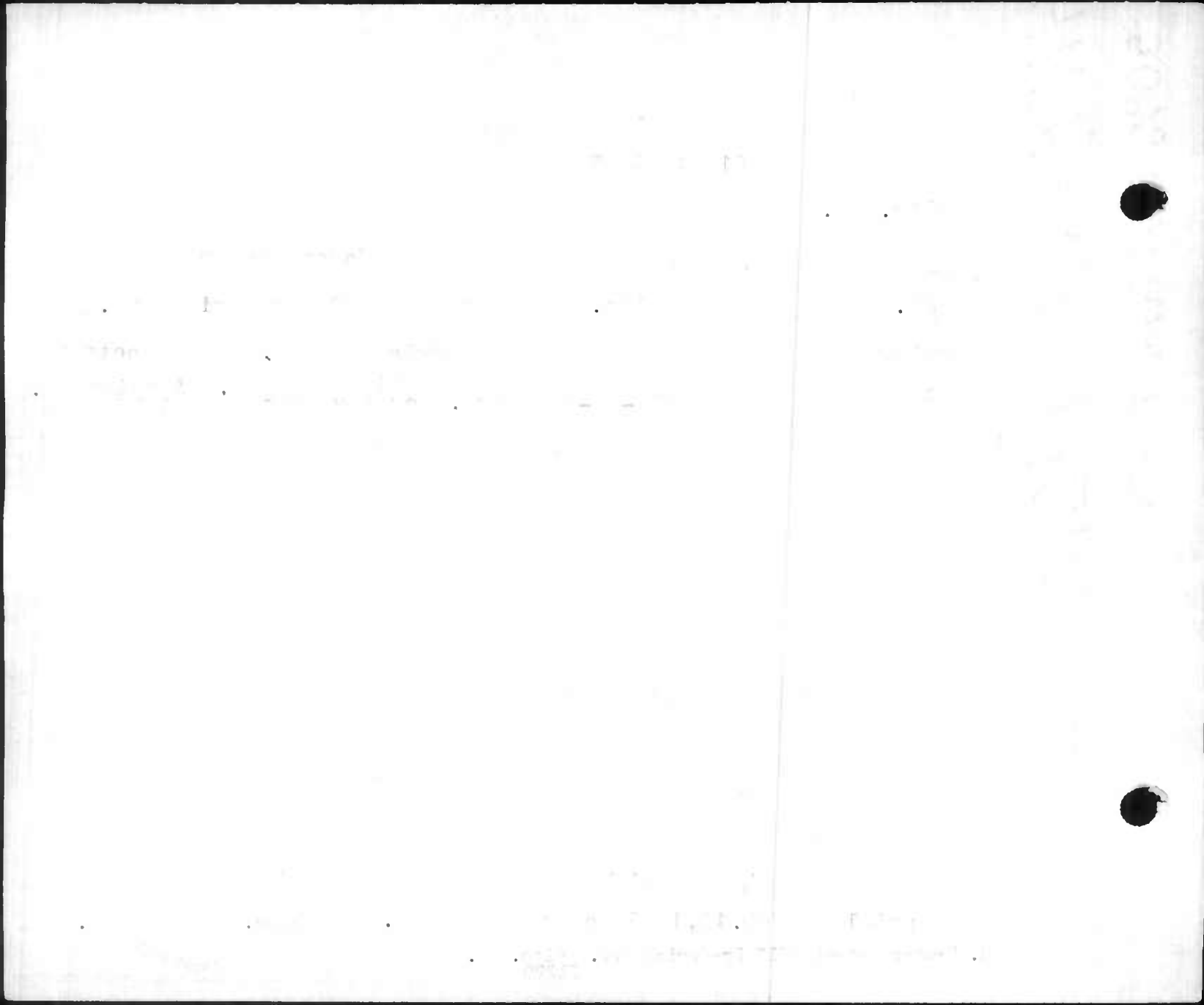


TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH THE DEATH CERTIFICATE. PAGES 1 AND 2 SHOULD BE FILED WITHIN 24 HOURS AFTER DEATH. WITHIN 24 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | | | | | | | | | | | | | |
|---|--|-------------------------|--|---|--|---|--|---|--|--|--|---|--|--|--|--|--|--|--|
| 1. FOR STATE REGISTRAR | | | | | | | | | | 5 2 0 3 7 9 3 | | | | | | | | | |
| 1. DECEASED NAME
(TYPE OR PRINT) PEGGY A. HAMMER | | | | | | | | | | 2a. DATE KNOWN OF DEATH <input checked="" type="checkbox"/> MONTH 2 DAY 11 YEAR 19 82 | | | | | | | | | |
| 3. SEX
female | | 4. RACE
white | | 5. DATE OF BIRTH
MONTH 5 DAY 21 YEAR 1934 | | 6. AGE (IN YEARS)
LAST BIRTHDAY 47 YRS. | | IF UNDER 1 YR.
MONTHS DAYS HOURS MIN | | IF UNDER 24 HRS.
MONTHS DAYS HOURS MIN | | 2c. DATE PRONOUNCED DEAD
MONTH 2 DAY 11 YEAR 19 82 | | 2b. HOUR
10:01 PM | | | | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
Balto. Md. | | | | 7b. CITIZEN OF WHAT COUNTRY?
U S A | | | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | | | 9. BALTIMORE CITY OR COUNTY OF DEATH
Baltimore City MD. | | | | | | | |
| 10. CITY OR TOWN OF DEATH
Baltimore | | | | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
St. Agnes Hospital (DOA) | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)
House Keeper | | | | 12b. KIND OF BUSINESS OR INDUSTRY | | | | | | | |
| USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) | | | | | | | | | | | | | | | | | | | |
| 13a. STATE
Md. | | 13b. COUNTY | | 13c. CITY OR TOWN
Balto. | | 13d. INSIDE CITY LIMITS?
<input checked="" type="checkbox"/> YES <input type="checkbox"/> NO | | 13e. STREET ADDRESS
3009 Frederick Ave. | | | | | | | | | | | |
| 14. FATHER'S NAME
FIRST Arthur MIDDLE LAST Hammer | | | | 15. MOTHER'S MAIDEN NAME
FIRST Carrie MIDDLE S. LAST Goetzke | | | | | | | | | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO, OR UNKNOWN) no | | | | 16b. SOCIAL SECURITY NO.
219-30-2997 | | | | 17. INFORMANT ADDRESS
504 Surrey Rd. Timonium Md. 21093 | | | | | | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I DEATH WAS CAUSED BY:
4280 IMMEDIATE CAUSE (a) Congestive heart failure
Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last:
(b)
(c) | | | | | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | | | | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: | | | | | | | | | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | | | | | | | | 20. AUTOPSY?
<input checked="" type="checkbox"/> YES <input type="checkbox"/> NO | | | | | | | |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH | | | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) | | | | | | | | | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/> | | | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) | | | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | | | | | | | | | |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> . Inspection <input type="checkbox"/> . Inquiry <input type="checkbox"/> . and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> . Accident <input type="checkbox"/> . Suicide <input type="checkbox"/> . Homicide <input type="checkbox"/> . Undetermined manner <input type="checkbox"/> . | | | | | | | | | | | | | | | | | | | |
| ACTUAL SIGNATURE Ann M. Dixon | | | | TITLE (SPECIFY) Assistant | | | | DATE SIGNED 2-12-82 | | | | | | | | | | | |
| EXAMINER'S NAME (TYPE OR PRINT) Ann M. Dixon, M.D. | | | | ADDRESS 111 Penn St. | | | | | | | | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | | | | 23b. DATE Feb. 15, 1982 | | | | 23c. NAME OF CEMETERY OR CREMATORY Loudon Park Cem. | | | | 23d. LOCATION
CITY OR TOWN Balto. COUNTY Md. STATE | | | | | | | |
| 24. FUNERAL DIRECTOR G. Truman Schwab | | | | 3512 Frederick Ave. Balto. Md. 21229 | | | | 25a. DATE REC'D. BY REGISTRAR FEB 19 1982 | | | | 25b. REGISTRAR'S SIGNATURE [Signature] | | | | | | | |



STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 2 0 3 / 9 4

FOR
STATE
REGISTRAR

REG. NO.

| | | | | | | |
|---|---|---|--|--|---|--|
| 1. DECEASED NAME
(TYPE OR PRINT)
LEONA E. HANDLER | | | 2a. DATE OF DEATH
2-26-82 | | 2b. HOUR
12 35 AM | |
| 3. SEX
Female | 4. RACE
White | 5. DATE OF BIRTH
MONTH Jan. DAY 17 YEAR 1889 | | 6. AGE (IN YEARS LAST BIRTHDAY)
93 | IF UNDER 1 YEAR
MONTHS YRS. DAYS HOURS MIN. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
Maryland | 7b. CITIZEN OF WHAT COUNTRY?
U.S.A. | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
BALTIMORE CITY MD. | | |
| 10. CITY OR TOWN OF DEATH
CITY Baltimore | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
THE UNION MEMORIAL HOSPITAL | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
Homemaker | | 12b. KIND OF BUSINESS OR INDUSTRY | |
| 13a. STATE
Maryland | | 13b. COUNTY | 13c. CITY OR TOWN
Baltimore | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | 13e. STREET ADDRESS
Balt., Md. 21214
3502 Southern Ave. | |
| 14. FATHER'S NAME
FIRST Charles MIDDLE DeMartello LAST Charles | | 15. MOTHER'S MAIDEN NAME
FIRST Elizabeth MIDDLE Winant LAST Elizabeth | | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN) No | | |
| 16b. SOCIAL SECURITY NO.
213-52-9680 | | 17. INFORMANT
Son: Charles M. Handler | | ADDRESS Balt., Md. 21214
3502 Southern Ave. | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART 1. DEATH WAS CAUSED BY:
2765 IMMEDIATE CAUSE (a) RESPIRATORY ARREST
DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b) _____
DUE TO, OR AS A CONSEQUENCE OF
(c) _____ | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)
DEHYDRATION, POSS SEPSIS, Multiple Decubiti | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF FATHER, MOTHER, MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED. (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | |
| 22a. I certify that (1) this hospital attended the deceased from ON 2/26/82 to 19 that (1) (we) last saw the decedent alive on N.A. 19 and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (If yes) (If no) (If did not view the body after death) | | | | | | |
| 22b. SIGNATURE
Robert J. Varipapa | | DEGREE | | ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> | | 22c. DATE SIGNED
2/26/82 |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
ROBERT VARIPAPA M.D. | | 22e. ADDRESS
201 UNIVERSITY PARKWAY | | | | |
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)
Burial | | 23b. DATE
Mar 1 1982 | | 23c. NAME OF CEMETERY OR CREMATORY
Mt. Olivet Cemetery | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
Baltimore, Maryland |
| 24. FUNERAL DIRECTOR
NAME
Leonard J. Ruck, Inc. | | ADDRESS
Baltimore, Maryland | | 25a. DATE REC'D. BY REGISTRAR
MAR 1 1982 | | |
| 25b. REGISTRAR'S SIGNATURE
Frances S. Smith | | | | | | |

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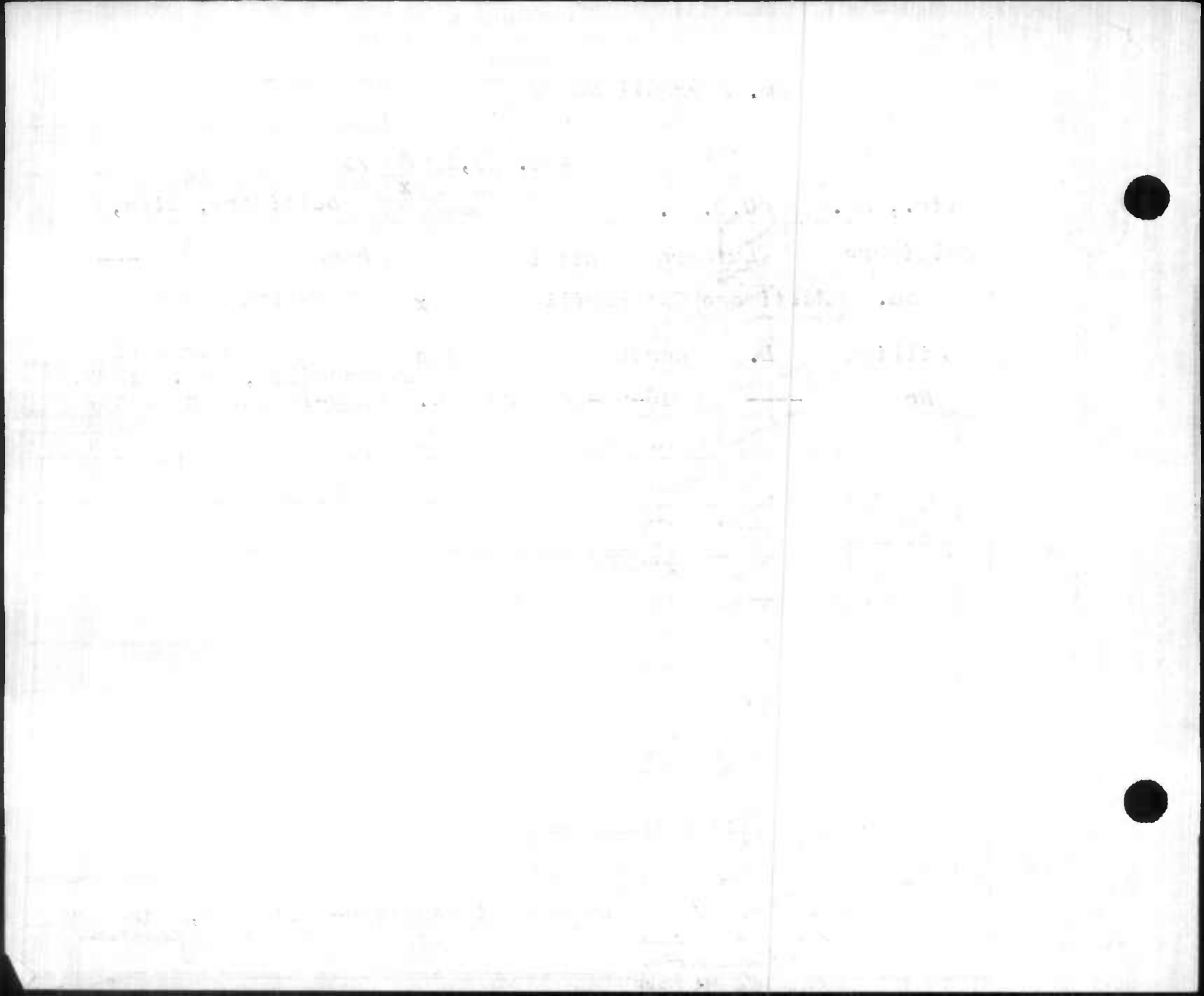
1917

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon copies. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH | | | | 8 2 0 3 7 9 5 | |
|--|---|--|--|--|---|
| 1. FOR STATE REGISTRAR | | REG. NO. | | | |
| 1. DECEASED NAME (TYPE OR PRINT)
Wm. Marshall Handy
Wm. William M. HANDY | | 2a. DATE OF DEATH MONTH DAY YEAR
2 1 2 3 1 8 2 | | 2b. HOUR
5:52 AM | |
| 3 SEX
Male | 4 RACE
White | 5. DATE OF BIRTH MONTH DAY YEAR
Sept. 25, 1908 | | 6. AGE (IN YEARS LAST BIRTHDAY) YRS. MONTHS DAYS
73 | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
Balto., Md. | 7b. CITIZEN OF WHAT COUNTRY?
U.S. A. | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
Baltimore, City, MD. | |
| 10. CITY OR TOWN OF DEATH
Baltimore | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
Luthern Hospital | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)
None | | 12b. KIND OF BUSINESS OR INDUSTRY
--- |
| 13a. STATE
Md. | 13b. COUNTY
Baltimore | 13c. CITY OR TOWN
Catonsville | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | 13e. STREET ADDRESS
18 Dutton Avenue | |
| 14. FATHER'S NAME FIRST MIDDLE LAST
William L. Handy | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST
Helen Marshall | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No | | 16b. SOCIAL SECURITY NO.
216-60-6230 | | 17. INFORMANT ADDRESS
John C. Handy-18 Dutton Avenue Catonsville, Md. 21228. | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART 1. DEATH WAS CAUSED BY:
4275 IMMEDIATE CAUSE (a) Cardiopulmonary Arrest
DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.
(b) _____
DUE TO, OR AS A CONSEQUENCE OF
(c) _____ | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) _____ | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | |
| 22a. I certify that (I) (this hospital) attended the deceased from 2 1 1 5 , 19 8 2 , to 2 1 2 3 , 19 8 2 , that (I) (we) lost
saw the deceased alive on 2 1 2 3 , 19 8 2 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated
above, (I) (we) (did) (did not) view the body after death. | | | | | |
| 22b. SIGNATURE
Richard Chasen | | DEGREE | | 22c. DATE SIGNED
2 1 2 3 1 8 2 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
RICHARD CHASEN, M.D. | | 22e. ADDRESS
730 Ashburton St. Balt., Md. | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)
Burial | | 23b. DATE
2/25/82 | | 23c. NAME OF CEMETERY OR CREMATORY
Greenmount Cemetery-Baltimore | |
| 23d. LOCATION CITY OR TOWN
Baltimore | | COUNTY
Maryland | | STATE | |
| 24. FUNERAL DIRECTOR NAME
Starling Funeral Estate | | ADDRESS
736 Edmondson Ave. Catonsville, Md. 21228 | | 25a. DATE REC'D. BY REGISTRAR
MAR 1 1982 | |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified in person.

DHMH - 16 50M 1/81
(VRA 15, 4)STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

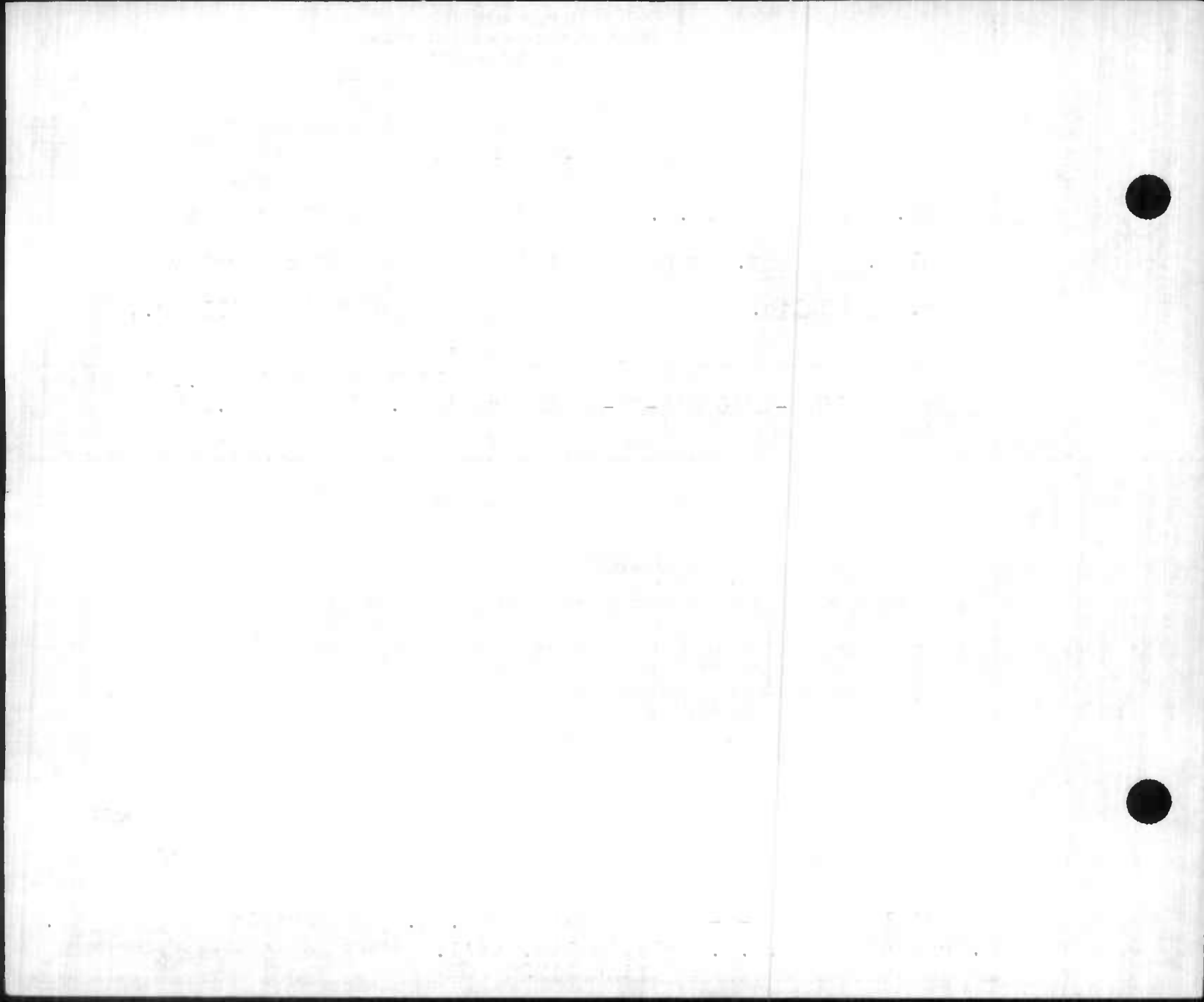
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REG. NO.

1 - FOR
STATE
REGISTRAR

| | | | | | |
|---|---|---|---|--|--|
| 1. DECEASED NAME
(TYPE OR PRINT) FIRST MIDDLE LAST
Roy W Hankey | | | 2a. DATE OF DEATH MONTH DAY YEAR
2/27/82 | | 2b. HOUR
3:40 A.M. |
| 3. SEX
MALE | 4. RACE
White | 5. DATE OF BIRTH MONTH DAY YEAR
10 1 18 | 6. AGE (IN YEARS LAST BIRTHDAY)
63 YRS. | | IF UNDER 1 YEAR MONTHS DAYS
IF UNDER 24 HRS. HOURS MIN. |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
Md. | 7b. CITIZEN OF WHAT COUNTRY?
U.S.A. | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 9. BALTIMORE CITY OR COUNTY OF DEATH
Baltimore City MD | | |
| 10. CITY OR TOWN OF DEATH
Balto. | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
St. Agnes Hospital | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
Letter Carrier | | |
| 13a. STATE
Md. | | 13b. CITY OR TOWN
Balto. | 13c. INSIDE CITY LIMITS?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | 13d. STREET ADDRESS
6220 Oak Hill Dr., 21228 | |
| 14. FATHER'S NAME FIRST MIDDLE LAST
Roy Hankey | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST
Annie Fink | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)
Yes 1944-1946 | | 16b. SOCIAL SECURITY NO.
215-09-5885 | | 17. INFORMANT ADDRESS
Patricia A. Culton Md., 21048 | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART 1. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>CARDIAC ARREST</u>
4100 } DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which } (b) <u>MYOCARDIAL INFARCTION</u>
gave rise to immediate }
cause (c), stating the }
underlying cause last. } DUE TO, OR AS A CONSEQUENCE OF
(c) | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: 18 | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input type="checkbox"/> | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK AT WORK | | 21e. PLACE OF INJURY
(AT HOME STREET FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | |
| 22a. I certify that (he) (this hospital) attended the deceased from 2-19-82 to 2-27-82, that (he) (we) last saw the deceased alive on 2-27-82, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (he) (we) (did) (did not) view the body after death. | | | | | |
| 22b. SIGNATURE
Geetha Raja | | DEGREE
RESIDENT | | 22c. DATE SIGNED
2-27-82 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
GEETHA RAJA | | 22e. ADDRESS
900 CATON AVE, BALT, MD-21229 | | | |
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)
Burial | | 23b. DATE
3-2-82 | 23c. NAME OF CEMETERY OR CREMATORY
Lakeview Mem. Pk. | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
Sykesville MD |
| 24. FUNERAL DIRECTOR
G. Truman Schwab, P.A. | | 5151 Balto. Nat'l
Pike 21229 | | 25a. DATE BY REGISTRAR
MAR 4 1982 | |

25b. REGISTRAR'S SIGNATURE



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 must be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

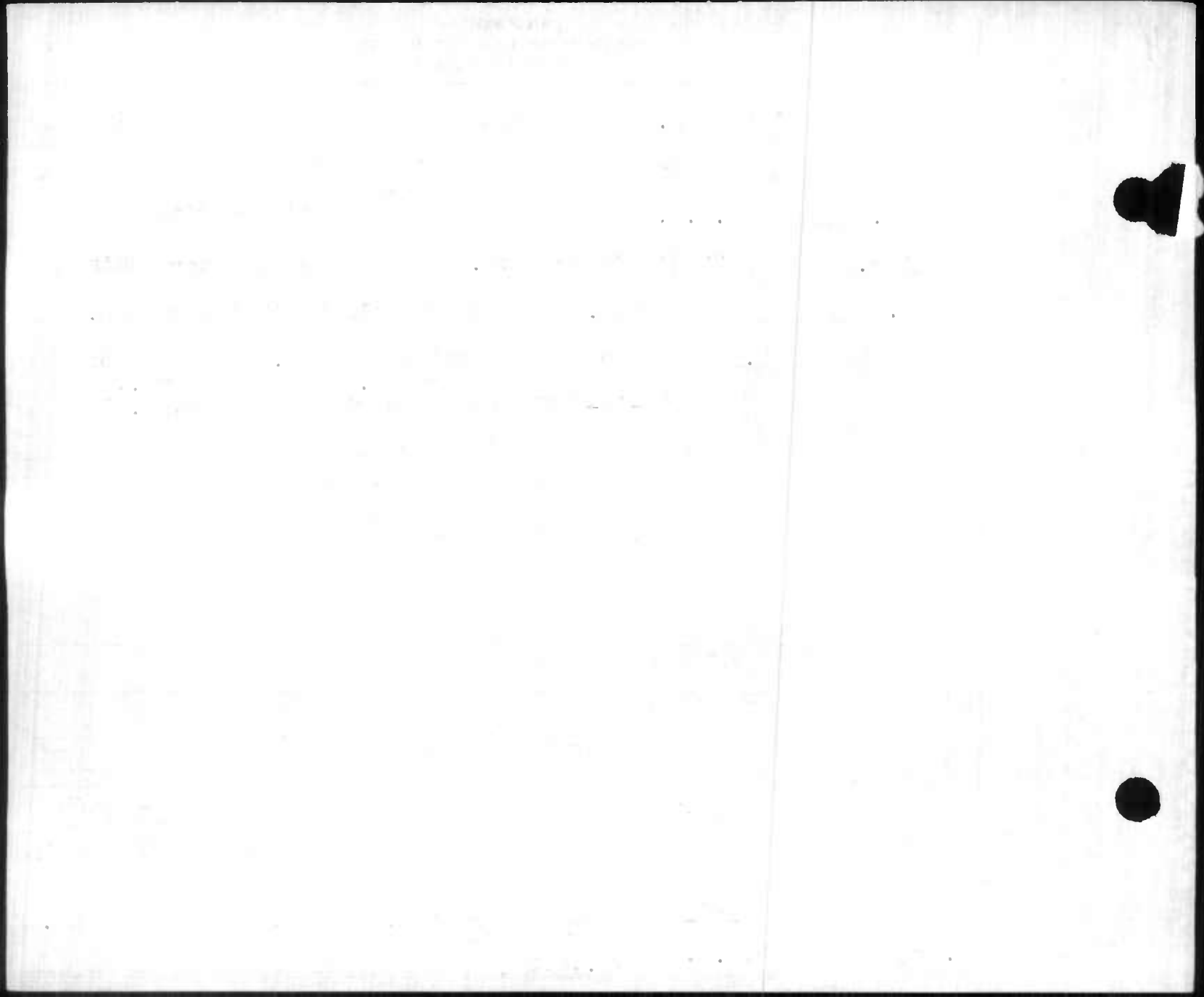
1- FOR
STATE
REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 2 0 3 7 9 7

REG. NO.

| | | | | | | | |
|--|--|---|--|--|---|---|--|
| 1. DECEASED NAME
(TYPE OR PRINT)
Charles J. Hanna | | | 2a. DATE OF DEATH
MONTH DAY YEAR
2 19 82 | | | 2b. HOUR
M | |
| 3. SEX
Male | | 4. RACE
White | | 5. DATE OF BIRTH
MONTH DAY YEAR
8 26 17 | | 6. AGE (IN YEARS LAST BIRTHDAY)
64 YRS | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
Md. | | 7b. CITIZEN OF WHAT COUNTRY?
U.S.A. | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
Baltimore City MD. | |
| 10. CITY OR TOWN OF DEATH
Balto. | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
1077 Wilmington Ave. | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
Radio Operator | | 12b. KIND OF BUSINESS OR INDUSTRY
Ship | |
| 13a. STATE
Md. | | 13b. COUNTY | | 13c. CITY OR TOWN
Balto. | | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 13e. STREET ADDRESS
1077 Wilmington Ave. | | | | | | | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
Charles W. Hanna | | | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
Evelyn A. Taylor | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
No | | 16b. SOCIAL SECURITY NO.
216-14-0371 | | 17. INFORMANT
ADDRESS
306 W. Chesapeake Ave.,
Eugene Schmidt Towson, Md. 21204 | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Cardio-Pulmonary arrest
4960
DUE TO, OR AS A CONSEQUENCE OF (b) an aortic aneurysm O.L.G.
DUE TO, OR AS A CONSEQUENCE OF (c) an aortic aneurysm with P.V.C.
CONDITIONS, IF ANY, WHICH GAVE RISE TO IMMEDIATE CAUSE (a), stating the underlying cause last | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | |
| 21d. INJURY OCCURRED
WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 1-5-75, 19, to 2-19-82, 19, that (I) (we) last saw the deceased alive on 2-7-82, 19, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death. | | | | | | | |
| 22b. SIGNATURE
George Angov | | | | DEGREE
ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | 22c. DATE SIGNED
2-19-82 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
GEORGE ANGOV | | | | 22e. ADDRESS
3550 Wilkins Dr. Baltimore, Md. | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)
Burial | | 23b. DATE
2-22-82 | | 23c. NAME OF CEMETERY OR CREMATORY
Loudon Park Cem. | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
Balto. Md. | |
| 24. FUNERAL DIRECTOR
NAME
G. Truman Schwab, P.A. | | | | 25a. DATE REC'D. BY REGISTRAR
FEB 25 1982 | | 25b. REGISTRAR'S SIGNATURE
[Signature] | |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4, if any, be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

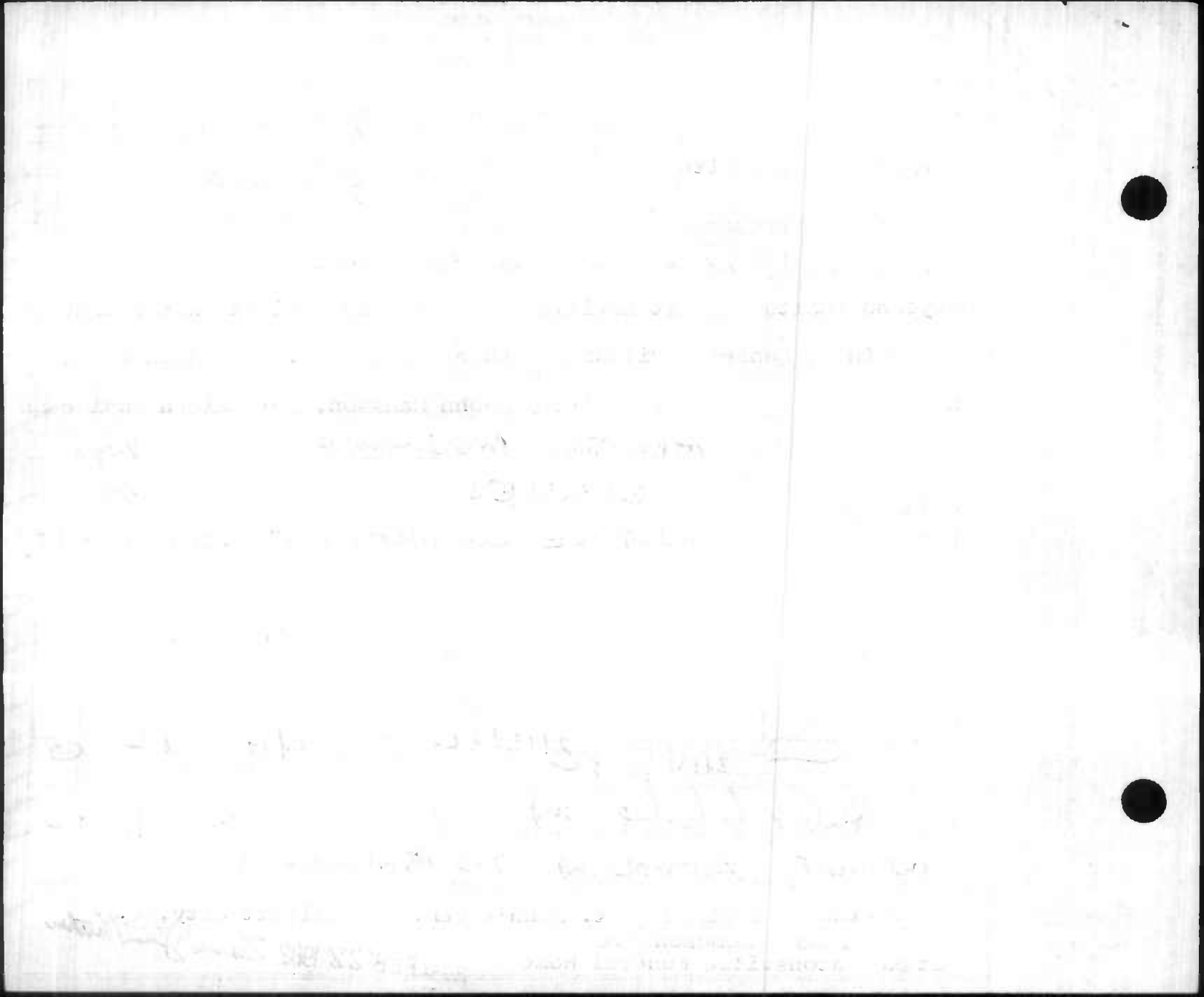
IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1. FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 2 0 3 1 9 8

REG. NO.

| | | | | | |
|---|--|---|---|---|---|
| 1. DECEASED NAME
(TYPE OR PRINT)
FIRST MIDDLE LAST
LORRAINE WILCOX HANSSON | | | 2a. DATE OF DEATH
MONTH DAY YEAR
2/19/82 | | 2b. HOUR
7A M |
| 3 SEX
Female | 4 RACE
White | 5. DATE OF BIRTH
MONTH DAY YEAR
6 7 12 | | 6 AGE (IN YEARS LAST BIRTHDAY)
69 YRS. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
MD | 7b. CITIZEN OF WHAT COUNTRY?
USA | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9 BALTIMORE CITY OR COUNTY OF DEATH
BALTO City MD | |
| 10. CITY OR TOWN OF DEATH
BALTO | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
LUTHERAN HOSPITAL | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
Housewife | | 12b. KIND OF BUSINESS OR INDUSTRY |
| 13a. STATE
Maryland | | 13b. COUNTY
Balto | 13c. CITY OR TOWN
Catonsville | 13d. INSIDE CITY LIMITS?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
Edwin Daniel Wilcox | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
Lula B. Barnes | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
no | | 16b. SOCIAL SECURITY NO.
21501-AL57 | | 17. INFORMANT
ADDRESS
John Hansson, 201 Maiden Choice Ln | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART 1. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) 1910 ASPIRATION PNEUMONIA
DUE TO, OR AS A CONSEQUENCE OF
(b) SEIZURES
DUE TO, OR AS A CONSEQUENCE OF
(c) MULTIPLE COLORECTAL METASTASES | | | | | APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATH
Days
Days
months |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 20b. IF YES, WERE FINDINGS USED
IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | | |
| 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK AT WORK | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | |
| 22a. I certify that (I) (this hospital) attended the deceased from 2/12/82, 19 82, to 2/19, 19 82, that (I) (we) last saw the deceased alive on 2/19, 19 82, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | |
| 22b. SIGNATURE
Herbert A. Kube MD | | DEGREE
MD | | 22c. DATE SIGNED
2/19/82 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
HERBERT Kustowicz MD | | 22e. ADDRESS
730 ASKOWNOW ST. | | | |
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)
Burial | | 23b. DATE
2/22/82 | | 23c. NAME OF CEMETERY OR CREMATORY
St. John's Cem. | |
| 23d. LOCATION
CITY OR TOWN COUNTY STATE
Ellicott City, Md | | 24. FUNERAL DIRECTOR
NAME ADDRESS
1630 Edmondson Ave
Witzke Catonsville Funeral Home | | | |
| 25a. DATE REC'D. BY REGISTRAR
FEB 22 1982 | | 25b. REGISTRAR'S SIGNATURE
Charles J. Sweeney | | | |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the registrar, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

4

1. FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

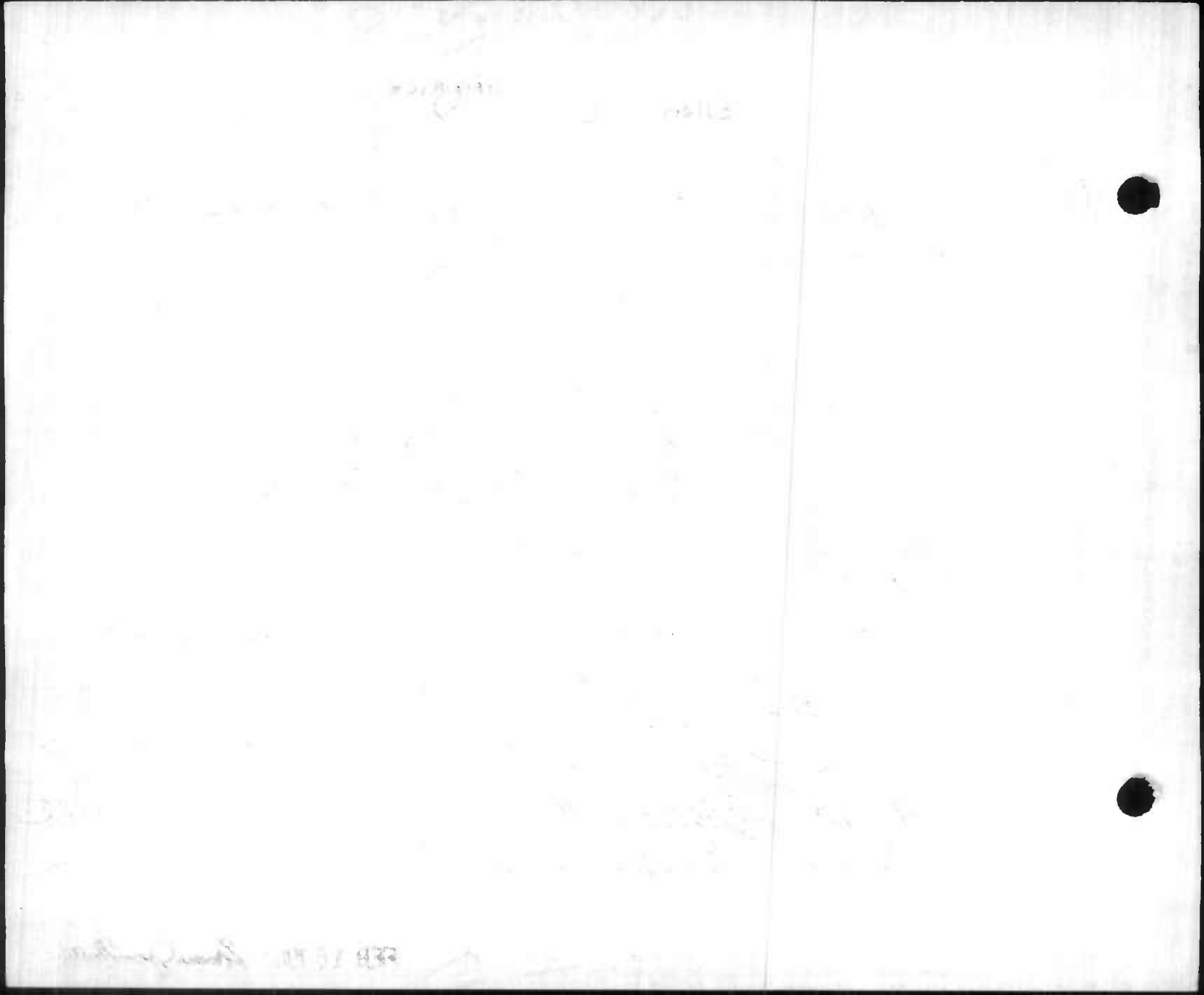
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REG. NO.

| | | | | | |
|---|--|---|--|---|--|
| 1. DECEASED NAME
(TYPE OR PRINT)
FIRST MARY MIDDLE Ellen LAST (HARDWICK) | | 2a. DATE OF DEATH
MONTH DAY YEAR
2 16 82 | | 2b. HOUR
12:30 A | |
| 3. SEX
Female | | 4. RACE
Black | | 5. DATE OF BIRTH
MONTH DAY YEAR
5 4 97 | |
| 6. AGE (IN YEARS LAST BIRTHDAY)
84 YRS. | | 7a. BIRTHPLACE
STATE OR FOREIGN COUNTRY
GEORGIA | | 7b. CITIZEN OF WHAT COUNTRY?
USA | |
| 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
BALTIMORE CITY MD. | | | |
| 10. CITY OR TOWN OF DEATH
BALTIMORE, MO. | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
Provident Hospital | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE) | |
| 12b. KIND OF BUSINESS OR INDUSTRY | | | | | |
| 13a. STATE
MD | | 13b. COUNTY | | 13c. CITY OR TOWN
Baltimore | |
| 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS
468 Tubman Ct. | | | |
| 14. FATHER'S NAME
FIRST Middle LAST
George Butler | | 15. MOTHER'S MAIDEN NAME
FIRST Middle LAST
Elsie | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
No | | 16b. SOCIAL SECURITY NO.
219-14-1439 | | 17. INFORMANT
ADDRESS
Elder Charles Brown 3201 Hillsdale | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY
IMMEDIATE CAUSE (a) <u>CARDIO PULMONARY ARREST</u>
1579
DUE TO, OR AS A CONSEQUENCE OF
(b) <u>METASTATIC PANCREATIC CARCINOMA</u>
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last
DUE TO, OR AS A CONSEQUENCE OF
(c) _____
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)
N/A | | | | | |
| 19a. DATE OF OPERATION
N/A | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED
N/A | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. N/A 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)
N/A | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/>
AT WORK <input type="checkbox"/> AT WORK <input checked="" type="checkbox"/> | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)
N/A | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE
N/A | |
| 22a. I certify that (I) (this hospital) attended the deceased from 2/15 19 82 to 2/16 19 82 that (I) (we) last saw the deceased alive on 2/15 19 82, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | |
| 22b. SIGNATURE
Melva J. Brown, MD. | | | | 22c. DATE SIGNED
2/16/82 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
MELVA J. BROWN, MD. | | | | 22e. ADDRESS
PROVIDENT HOSPITAL
2600 LIBERTY HEIGHTS, BALTIMORE, MD. | |
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)
Burial | | 23b. DATE
2/19/82 | | 23c. NAME OF CEMETERY OR CREMATORY
King Mem. Park | |
| 23d. LOCATION
CITY OR TOWN COUNTY STATE
Baltimore Co. MD | | | | | |
| 24. FUNERAL DIRECTOR
NAME
Wm. C. March F/H | | ADDRESS
1101 E. North Ave. | | 25a. DATE REC'D. BY REGISTRAR
FEB 16 1982 | |
| | | 25b. REGISTRAR'S SIGNATURE
Ramon J. [Signature] | | | |

MEDICAL CERTIFICATION

BP

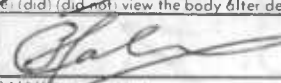



DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 2 0 3 8 0 0

1- FOR
STATE
REGISTRAR

REG. NO.

| | | | | | | | | | |
|--|--|--|--|---|--|---|--|--|--|
| 1. DECEASED NAME
(TYPE OR PRINT)
FIRST MIDDLE LAST
DORIS L. HARGADON | | | 2a. DATE OF DEATH
MONTH DAY YEAR
2/15/82 | | 2b. HOUR
11:25 | | | | |
| SEX
FEMALE | | 4. RACE
WHITE | | 5. DATE OF BIRTH
MONTH DAY YEAR
11 10 18 | | 6. AGE (IN YEARS LAST BIRTHDAY)
64 63 YRS
IF UNDER 1 YEAR
MONTHS DAYS HOURS MIN. | | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
MARYLAND | | 7b. CITIZEN OF WHAT COUNTRY?
U.S.A. | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
BALTIMORE CITY MD. | | | |
| 10. CITY OR TOWN OF DEATH
BALTIMORE | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
ST. AGNES HOSPITAL | | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
UNKNOWN | | 12b. KIND OF BUSINESS OR INDUSTRY
CLOTHING | | |
| 13a. STATE
MARYLAND | | 13b. COUNTY
--- | | 13c. CITY OR TOWN
BALTIMORE | | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS
631 S. PULASKI STREET, 21223 | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
PHILLIP EMRICH | | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
MARY NICHOLSON | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
NO | | 16b. SOCIAL SECURITY NO.
213-10-3533 | | 17. INFORMANT
ADDRESS
MARGARET ROSKELLY 1612 PARKMAN AVENUE 21230 | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART 1. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) LIVER FAILURE
1991
DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last
(b) METASTATIC ADENOCARCINOMA
DUE TO, OR AS A CONSEQUENCE OF
(c) ---
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
1 WEEK
MONTHS | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:
--- | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | | | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK AT WORK | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 1/15/1982 to 2/10/1982 , that (I) (we) lost
saw the deceased alive on 2/15/1982 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated
above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | |
| 22b. SIGNATURE
 | | DEGREE
M.D. ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> | | | | | 22c. DATE SIGNED
2/15/82 | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
Dr. Cornelius Halma | | 22e. ADDRESS
Saint Agnes Hospital
900 CATON AVENUE BALTIMORE | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)
BURIAL | | 23b. DATE
02-19-82 | | 23c. NAME OF CEMETERY OR CREMATORY
LOUDON PARK | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
BALTIMORE CITY MARYLAND | | | |
| 24. FUNERAL DIRECTOR
NAME
HUBBARD FUNERAL HOME, INC. | | ADDRESS
4107 WILKENS AVE. | | 25a. DATE REC'D. BY REGISTRAR
FEB 19 1982 | | 25b. REGISTRAR'S SIGNATURE
 | | | |

10

(M)

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be called at once.



FEB 18 1965

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

Item 13e per phone 2/9/82 dad

STATE OF MARYLAND

DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 2 0 3 8 0 1

REG. NO.

| | | | | | |
|---|--|--|---|--|--|
| 1. STATE REGISTRAR | | 2a. DATE OF DEATH | | 2b. HOUR | |
| 1. DECEASED NAME (TYPE OR PRINT) | | 2a. DATE OF DEATH | | 2b. HOUR | |
| JOHN ARLISS HARGRAVE | | 2 2 82 | | 8:40pM | |
| 3. SEX | 4. RACE | 5. DATE OF BIRTH | 6. AGE (IN YEARS LAST BIRTHDAY) | IF UNDER 1 YEAR | |
| MALE | BLACK | 2 24 16 | 65 | IF UNDER 24 HRS. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) | 7b. CITIZEN OF WHAT COUNTRY? | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 9. BALTIMORE CITY OR COUNTY OF DEATH | | |
| NORTH CARALINIA | U.S.A. | | BALTIMORE CITY, MD | | |
| 10. CITY OR TOWN OF DEATH | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | | |
| BALTIMORE | VETERANS ADMINISTRATION MEDICAL CENTER | | 12b. KIND OF BUSINESS OR INDUSTRY | | |
| 13a. STATE | 13b. COUNTY | 13c. CITY OR TOWN | 13d. INSIDE CITY LIMITS? | 13e. STREET ADDRESS | |
| MARYLAND | | BALTIMORE | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | 200 Hiltion St. | |
| 14. FATHER'S NAME | 15. MOTHER'S MAIDEN NAME | | | | |
| JOHN WESLEY HARGRAVE | MINNIE HOLT | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) | 16b. SOCIAL SECURITY NO. | 17. INFORMANT ADDRESS | | | |
| YES | WWII | 245107668 VAMC Medical Records 3900 LOCH RAVEN BLVD | | | |
| 18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: | | | | | |
| IMMEDIATE CAUSE (a) <i>Right upper & lower lobe carcinoma</i> | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF (b) <i>Right upper & lower lobe carcinoma</i> | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF (c) | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1. a | | | | | |
| 19a. DATE OF OPERATION | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | 20a. AUTOPSY? | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? | | |
| | | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | |
| | | | | | |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | |
| | | | | | |
| 22a. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from FEBRUARY 2, 19 82, to FEBRUARY 2, 19 82, that <input checked="" type="checkbox"/> (we) lost saw the deceased above <input checked="" type="checkbox"/> (we) (did) <input type="checkbox"/> (we) (did not) by the body after death. | | | | | |
| 22b. SIGNATURE | | DEGREE | | 22c. DATE SIGNED | |
| <i>K. Neuman MD</i> | | ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | 2-3-82 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) | | 22e. ADDRESS | | | |
| Neuman | | 3900 LOCH RAVEN BLVD BALTIMORE, MD 21218 | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) | 23b. DATE | 23c. NAME OF CEMETERY OR CREMATORY | 23d. LOCATION CITY OR TOWN COUNTY STATE | | |
| BURIAL | 2-8-82 | CHELTENHAM VET. CEMT. | CHELTENHAM, MARYLAND | | |
| 24. FUNERAL DIRECTOR NAME | | 25a. DATE RECEIVED BY REG. OFF. (FEB 4 1982) | | 25b. DATE RECEIVED BY REG. OFF. (FEB 4 1982) | |
| E.L. PHILLIPS | | 1721 N. MONROE STREET | | | |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

| STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH | | | | | | | | | |
|---|--|--|-------------------|--|---------------------|--|-----------------------------------|---|--|
| 1. FOR STATE REGISTRAR | | 8 2 0 3 8 0 2 | | | | | | | |
| 1. DECEASED NAME (TYPE OR PRINT) | | 2a. DATE OF DEATH | | | | 2b. HOUR | | | |
| MOSES HARPER | | 2 7 82 | | | | 11:00 PM | | | |
| 3. SEX | 4. RACE | 5. DATE OF BIRTH | | 6. AGE (IN YEARS LAST BIRTHDAY) | | IF UNDER 1 YEAR | | IF UNDER 24 HRS. | |
| MALE | BLACK | 7 MONTH 31 DAY 31 YEAR | | 50 YRS | | MONTHS DAYS | | HOURS MIN. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) | 7b. CITIZEN OF WHAT COUNTRY? | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH | | | | | |
| NORTH CAROLINA | U.S.A. | | | BALTIMORE, CITY MD | | | | | |
| 10. CITY OR TOWN OF DEATH | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | | | 12b. KIND OF BUSINESS OR INDUSTRY | | |
| BALTIMORE | VAMC, 3900 LOCH RAVEN BLVD. | | | Labor | | | | | |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) | 13b. STATE | 13c. COUNTY | 13d. CITY OR TOWN | 13e. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | 13f. STREET ADDRESS | | | | |
| MARYLAND | | | BALTO | | 292 Mason Court | | | | |
| 14. FATHER'S NAME (FIRST MIDDLE LAST) | 15. MOTHER'S MAIDEN NAME (FIRST MIDDLE LAST) | | | 16. SOCIAL SECURITY NO. | | | | | |
| Moses Harper | Bessie Daniel | | | 242 42 2981 | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) | 16b. (IF YES, GIVE YEAR OR DATES) | | | 17. INFORMANT ADDRESS | | | | | |
| YES | WWII | | | Mr. Charles Harper | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Cardiopulmonary Arrest</u> 5715 | | | | | | | | | |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Bacterial Pneumonia / Renal Failure</u> | | | | | | | | | |
| (c) <u>Ascites / Liver Cirrhosis</u> | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (b) | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | | | |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | | | |
| 22a. I certify that XX (this hospital) attended the deceased from <u>1-24</u> , 19 <u>82</u> , to <u>2-7</u> , 19 <u>82</u> , that XX (we) lost saw the deceased alive on <u>2-7</u> , 19 <u>82</u> , and that in XX (our) opinion death occurred on the date and hour and from the causes stated above, XX (we) (did) XXXX view the body after death. | | | | | | | | | |
| 22b. SIGNATURE <u>Levitt Mrs</u> | | | | DEGREE | | | | 22c. DATE SIGNED <u>2/8/82</u> | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) <u>Levitt Mr</u> | | | | 22e. ADDRESS <u>3900 LOCH RAVEN BLVD. BALTO. MD. 21218</u> | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (IN FULL) | | 23b. DATE | | 23c. NAME OF CEMETERY OR CREMATORY | | 23d. LOCATION CITY OR TOWN COUNTY STATE | | | |
| Burial | | 2-13-82 | | Burial Chapel Ch. Com. | | Black Oak | | N.C. | |
| 24. FUNERAL DIRECTOR NAME <u>Joseph L. Russ</u> | | | | 25a. DATE REC'D. BY REGISTRAR <u>FEB 9 1982</u> | | 25b. REGISTRAR'S SIGNATURE <u>James J. Nathan</u> | | | |

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71

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53432

27

1-2

WICU

9 038 12 28

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician, it may be filled in by the funeral director. It should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 10 days of death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 2 0 3 8 0 3

REG. NO.

| | | | | | |
|---|--|---|---|--|--|
| 1. DECEASED NAME
(TYPE OR PRINT)
BENJAMIN PERCY HARRINGTON | | | 2a. DATE OF DEATH
MONTH DAY YEAR
February 04, 1982 | | 2b. HOUR
9:43p_M |
| 3. SEX
Male | 4. RACE
Black | 5. DATE OF BIRTH
MONTH DAY YEAR
6 28 1896 | 6. AGE (IN YEARS LAST BIRTHDAY)
85 YRS. | IF UNDER 1 YEAR
MONTHS DAYS
IF UNDER 24 HRS.
HOURS MIN. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
South Carolina | 7b. CITIZEN OF WHAT COUNTRY?
USA | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 9. BALTIMORE CITY OR COUNTY OF DEATH
BALTIMORE CITY MD. | | |
| 10. CITY OR TOWN OF DEATH
Baltimore | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
JOHNS HOPKINS HOSPITAL | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE) | | 12b. KIND OF BUSINESS OR INDUSTRY |
| 13a. STATE
MD | | 13b. CITY OR TOWN
Baltimore | 13c. STREET ADDRESS
1740 E. Lanvale St. | | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
Lewis Harrington | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
Frances Adams | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
No | | 16b. SOCIAL SECURITY NO.
213-01-4586 | | 17. INFORMANT
ADDRESS
Ida Mae Tubman 5005 Beaufort Ave. | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c))
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Hypotension
1369
Conditions, if any, which gave rise to immediate cause (b), stating the underlying cause last. (b) Sepsis shock
(c) Infection | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)
Possible Tuberculosis - malnutrition | | | | | |
| 19a. DATE OF OPERATION
— | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED
— | | 20a. AUTOPSY?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) | |
| 21d. INJURY OCCURRED
WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | |
| 22a. I certify that (1) this hospital attended the deceased from Jan 21/82 to Feb 4 19 82 that (b) we last saw the deceased alive on Feb 4 19 82 and that in (c) (our) opinion death occurred on the date and hour and from the causes stated above. (b) (we) did not view the body after death. | | | | | |
| 22b. SIGNATURE
B.B. Bolger MD | | DEGREE
MD | | 22c. DATE SIGNED
Feb 4/82 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
Bolger | | 22e. ADDRESS
Johns Hopkins Hosp 600 N Wolfe St Baltimore 21205 | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)
Burial | | 23b. DATE
2/8/82 | | 23c. NAME OF CEMETERY OR CREMATORY
Baltimore Cemetery | |
| 23d. LOCATION
CITY OR TOWN COUNTY STATE
Balto. MD | | | | | |
| 24. FUNERAL DIRECTOR
NAME
Wm. C. March F/H, Inc. | | | 25a. DATE REC'D. BY REGISTRAR
FEB 8 1982 | | |
| ADDRESS
1101 E. North Avenue | | | 25b. REGISTRAR'S SIGNATURE
James J. Nathan | | |

REC'D 860 P 0014

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 48 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified and a medical examination must be performed.

MEDICAL CERTIFICATION

| STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH | | | | 8 2 0 3 8 0 4 | | | |
|---|--|---|--|---|--|--|--|
| 1. FOR
STATE
REGISTRAR | | | | REG. NO. | | | |
| 1. DECEASED NAME
(TYPE OR PRINT) | | | | 2a. DATE OF DEATH | | 2b. HOUR | |
| FIRST MIDDLE LAST
CHARLES HENRY HARRIS SR. | | | | MONTH DAY YEAR
2 22 82 | | 3:35A M | |
| 3. SEX
MALE | | 4. RACE
BLACK | | 5. DATE OF BIRTH | | 6. AGE (IN YEARS LAST BIRTHDAY) | |
| MONTH DAY YEAR
9 4 23 | | 58 | | IF UNDER 1 YEAR
MONTHS DAYS | | IF UNDER 24 HRS.
HOURS MIN. | |
| 7a. BIRTHPLACE
(STATE OR FOREIGN COUNTRY)
GEORGIA | | 7b. CITIZEN OF WHAT COUNTRY?
U.S.A. | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
BALTIMORE CITY MD | |
| 10. CITY OR TOWN OF DEATH
BALTIMORE | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
VAMC, LOCH RAVEN BALTO. MD | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE) | | 12b. KIND OF BUSINESS OR INDUSTRY | |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)
13a. STATE
MARYLAND | | | | 13b. COUNTY | | 13c. CITY OR TOWN
BALTIMORE | |
| 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | | 13e. STREET ADDRESS
1524 N. SMALLWOOD ST 21216 | | | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
JOE HARRIS | | | | 15. MOTHER'S MAIDEN NAME
MIDDLE LAST
LFLIA RUCKER | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
YES | | 16b. SOCIAL SECURITY NO.
(IF YES, GIVE WAR OR DATES)
WWII | | 17. INFORMANT
Margaret L. Harris 1524 N. Smallwood St.
VAMC RECORDS LOCH RAVEN BLVD. BALTO. MD. TWO | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART 1. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>cardiopulmonary arrest</u>
5728
DUE TO, OR AS A CONSEQUENCE OF
(b) <u>liver failure</u>
DUE TO, OR AS A CONSEQUENCE OF
(c) _____
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:
<u>GI bleeding, s/p colonoscopy</u> | | | | | | | |
| 19a. DATE OF OPERATION
2/2/82 | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED
lower GI bleeding | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | |
| 22a. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <u>FEBRUARY 8</u> , 19 <u>82</u> , to <u>FEBRUARY 22</u> , 19 <u>82</u> , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on <u>FEBRUARY 22</u> , 19 <u>82</u> , and that in <input checked="" type="checkbox"/> (my) (our) opinion death occurred on the date and hour and from the causes stated above, <input checked="" type="checkbox"/> (we) (did) <input type="checkbox"/> (did not) view the body after death. | | | | | | | |
| 22b. SIGNATURE
W. Myers MD | | | | DEGREE
ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> | | 22c. DATE SIGNED
2/2/82 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
W. MYERS | | | | 22e. ADDRESS
3900 LOCH RAVEN BLVD. BALTO. MD. 21218 | | | |
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)
Burial | | 23b. DATE
2/27/82 | | 23c. NAME OF CEMETERY OR CREMATORY
Arbutus Mem. Park | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
Baltimore Co. MD | |
| 24. FUNERAL DIRECTOR
NAME
Wm. C. March F/H | | | | ADDRESS
1101 E. North Ave. | | 25a. DATE REC'D BY REGISTRAR
FEB 23 1982 | |
| | | | | 25b. REGISTRAR'S SIGNATURE
James J. Nathan | | | |

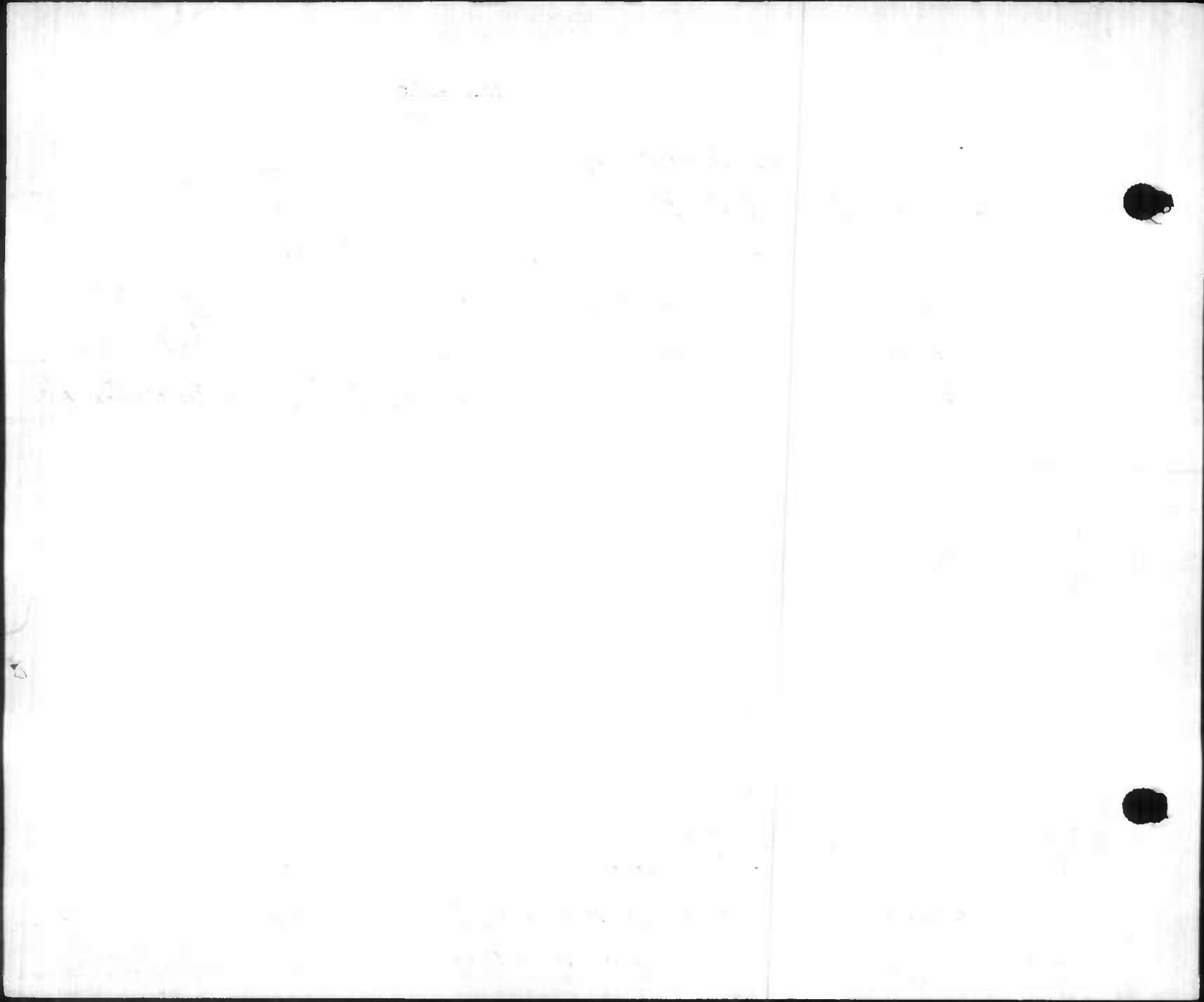
5881 EC 11-25

3

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

MEDICAL CERTIFICATION

| STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH | | | | | | | | | | REG. NO. 2 0 3 8 0 5 | |
|--|--|------------------|--|---|--|---|--|---|--|--|--|
| 1. FOR REGISTRAR | | | | | | | | | | | |
| 1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST
PHILLIP AKA Lewis HARRIS JR. | | | | | | | | | | 2a. DATE KNOWN OF DEATH ESTIMATED <input checked="" type="checkbox"/> MONTH DAY YEAR
2 6 1982 | |
| 3. SEX
male | | 4. RACE
negro | | 5. DATE OF BIRTH MONTH DAY YEAR
12-2-1954 27 YRS. | | 6. AGE (IN YEARS) (LAST BIRTHDAY) MONTHS DAYS HOURS MIN. | | 7c. DATE PRONOUNCED DEAD MONTH DAY YEAR
2 6 1982 | | 7d. HOUR P M
9:02 P M | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
BALTO. Md. | | | | 7b. CITIZEN OF WHAT COUNTRY?
U.S.A. | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
Baltimore City MD. | | | |
| 10. CITY OR TOWN OF DEATH
Baltimore | | | | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
Maryland General Hosp. (DOA) | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)
Tailor | | 12b. KIND OF BUSINESS OR INDUSTRY | |
| 12a. USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)
12a. STATE Maryland 12b. COUNTY 12c. CITY OR TOWN BALTO. | | | | | | | | | | 13a. STREET ADDRESS
4034 Hilltop Rd. | |
| 14. FATHER'S NAME FIRST MIDDLE LAST
Phillip Harris SR. | | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST
JUANITA Johnson | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, GIVE WAR OR DATES)
NO | | | | 16b. SOCIAL SECURITY NO.
219-62-6762 | | 17. INFORMANT ADDRESS
Mrs. Juanita Coote 4034 Hilltop Rd. | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Intravenous narcotism
3049 } DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. (b) }
DUE TO, OR AS A CONSEQUENCE OF (c) } | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | | | | | | 20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH | | | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2) | | | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/> | | | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) | | 21f. LOCATION CITY OR TOWN COUNTY STATE | | | | | |
| 22a. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> . | | | | | | | | | | | |
| ACTUAL SIGNATURE
Ann M. Dixon, M.D. | | | | TITLE (SPECIFY)
Assistant MEDICAL EXAMINER | | | | DATE SIGNED
2-7-82 | | | |
| EXAMINER'S NAME (TYPE OR PRINT)
Ann M. Dixon, M.D. | | | | ADDRESS
111 Penn St. | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)
Burial | | | | 23b. DATE
2-10-82 | | 23c. NAME OF CEMETERY OR CREMATORY
Mt. Auburn Cem. | | 23d. LOCATION CITY OR TOWN COUNTY STATE
Westport Md. | | | |
| 24. FUNERAL DIRECTOR NAME
Joseph L. Russ | | | | ADDRESS
2222 W. North Ave. | | 25a. DATE REC'D. BY REGISTRAR
FEB 16 1982 | | 25b. REGISTRAR'S SIGNATURE
Shane Jan North | | | |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4, may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of once.

| STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH | | | | | | | | | | REG. NO. 8 2 0 3 8 0 6 | | | | | |
|--|--|--|---|--|--|---|--|--|--|---|--|--|---|---|--|
| 1. FOR STATE REGISTRAR | | | | | | | | | | 2a. DATE OF DEATH | | 2b. HOUR | | | |
| 1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST
ROY Lee HARRIS, Sr. | | | | | | | | | | MONTH DAY YEAR
2 5 82 | | 9:17p M | | | |
| 3. SEX
MALE | | | 4. RACE
WHITE | | | 5. DATE OF BIRTH
MONTH DAY YEAR
2 20 96 | | | 6. AGE (IN YEARS LAST BIRTHDAY)
85 | | | IF UNDER 1 YEAR
MONTHS DAYS
YRS. | | IF UNDER 24 HRS.
HOURS MIN.
YRS. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN)
NORTH CAROLINA | | | 7b. CITIZEN OF WHAT COUNTRY?
U.S.A. | | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | | 9. BALTIMORE CITY OR COUNTY OF DEATH
Baltimore City MD. | | | | | | |
| 10. CITY OR TOWN OF DEATH
BALTIMORE | | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(GIVE FULL NAME AND STREET ADDRESS)
VAMC BALTIMORE, MARYLAND 21218 | | | | | | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
Crane Operator | | | 12b. KIND OF BUSINESS OR INDUSTRY
Beth. Steel | | |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)
13a. STATE MIDDLE LAST
MARYLAND Baltimore Edgemere | | | | | | | | | | 13b. INSIDE CITY LIMITS?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 13c. STREET ADDRESS
8613 OAK ROAD | | | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
James R. HARRIS, Jr. | | | | | | | | | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
Sally Sophronia ASHE | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES OR IF UNKNOWN)
YES | | | 16b. SOCIAL SECURITY NO.
WW1 224 07 4076 | | | 17. INFORMANT
ADDRESS
Frank B. Harris 6916 Homeway Road Balto., MD. 21222 | | | | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) transitional cell carcinoma, bladder
1889
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last
DUE TO, OR AS A CONSEQUENCE OF
b)
DUE TO, OR AS A CONSEQUENCE OF
c)
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
2 years. | | | | | | | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) | | | | | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | | | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) | | | | | | | | | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK AT WORK | | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | | | | | | | |
| 22a. I certify that (this hospital) attended the deceased from FEBRUARY 3, 19 82 , to FEBRUARY 5, 19 82 , that <input checked="" type="checkbox"/> (we) lost
saw the deceased alive on FEBRUARY 5, 19 82 , and that in <input checked="" type="checkbox"/> (our) opinion death occurred on the date and hour and from the causes stated
above, <input checked="" type="checkbox"/> (we) (did) NOT view the body after death. | | | | | | | | | | | | | | | |
| 22b. SIGNATURE
<i>William Loughlin Vetter</i> MD | | | | | | | | | | DEGREE
MD | | 22c. DATE SIGNED
2/5/82 | | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
William Loughlin Vetter, MD | | | | | | | | | | 22e. ADDRESS
Loch Raven VA Hospital | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)
Burial | | | 23b. DATE
2/9/1982 | | 23c. NAME OF CEMETERY OR CREMATORY
Meadowridge | | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
Dorsey Maryland | | | | | | | |
| 24. FUNERAL DIRECTOR
NAME ADDRESS
Duda-Ruck, Inc., 7922 Wise Avenue Dundalk, MD. 21222 | | | | | | | | | | 25a. DATE REC'D. BY REGISTRAR
FEB 9 1982 | | 25b. REGISTRAR'S SIGNATURE
<i>Thomas J. [Signature]</i> | | | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified to conduct an autopsy.

| Item 13e per phone 3/9/82 dad | | | | STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE | | 8 2 0 3 8 0 7 | |
|--|--|---|--|---|--|--|--|
| 1. STATE REGISTRAR | | | | CERTIFICATE OF DEATH | | | |
| 1. DECEASED NAME | | | | 2a. DATE OF DEATH | | 2b. HOUR | |
| FIRST MIDDLE LAST | | | | MONTH DAY YEAR | | HOUR MIN. | |
| WILLIAM E. HARRIS | | | | FEB 5 1982 | | 6:25 P.M. | |
| 3. SEX | | 4. RACE | | 5. DATE OF BIRTH | | 6. AGE | |
| MALE | | CAUC. | | 4/6/06 | | 75 YRS. | |
| 7a. BIRTHPLACE | | 7b. CITIZEN OF WHAT COUNTRY? | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH | |
| MD. | | U.S. | | | | BALTIMORE CITY MD. | |
| 10. CITY OR TOWN OF DEATH | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION | | 12a. USUAL OCCUPATION | | 12b. KIND OF BUSINESS OR INDUSTRY | |
| BALTIMORE | | UNION MEMORIAL HOSPITAL | | RETIRED | | | |
| 13a. STATE | | | | 13b. COUNTY | | 13c. CITY OR TOWN | |
| MD. | | | | | | BALTO. | |
| 14. FATHER'S NAME | | | | 15. MOTHER'S MAIDEN NAME | | 16. STREET ADDRESS | |
| FIRST MIDDLE LAST | | | | FIRST MIDDLE LAST | | 3620 Parkdale Ave. | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? | | | | 16b. SOCIAL SECURITY NO. | | 17. INFORMANT | |
| NO | | | | 216-09-481A WIFE | | ADDRESS | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) | | | | | | | |
| PART 1. DEATH WAS CAUSED BY: | | | | | | | |
| IMMEDIATE CAUSE (a) CEREBROVASCULAR ACCIDENT | | | | | | | |
| 4360 DUE TO, OR AS A CONSEQUENCE OF | | | | | | | |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. | | | | | | | |
| (b) DUE TO, OR AS A CONSEQUENCE OF | | | | | | | |
| (c) DUE TO, OR AS A CONSEQUENCE OF | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a | | | | | | | |
| HIGH BLOOD PRESSURE; DIABETES | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? | |
| | | | | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) | | | |
| | | HOUR A.M. MONTH DAY YEAR | | | | | |
| 21d. INJURY OCCURRED | | 21e. PLACE OF INJURY | | 21f. LOCATION | | | |
| WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | [AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.] | | STREET CITY OR TOWN COUNTY STATE | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from FEB 1 19 82, to FEB 5 19 82, that (I) (we) lost the deceased alive on FEB 5 19 82, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | |
| 22b. SIGNATURE | | | | DEGREE | | 22c. DATE SIGNED | |
| I. KELLY-DOKUBO M.D. | | | | M.D. | | FEB 5, 1982 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) | | | | 22e. ADDRESS | | | |
| I. KELLY-DOKUBO M.D. | | | | 4mt. | | | |
| 23a. BURIAL, CREMATION, REMOVAL | | 23b. DATE | | 23c. NAME OF CEMETERY OR CREMATORY | | 23d. LOCATION | |
| BURIAL | | 2/8/82 | | POPLAR GROVE | | BALTO. CO. MD. | |
| 24. FUNERAL DIRECTOR | | | | 25a. DATE REC'D. BY REGISTRAR | | 25b. REGISTRAR'S SIGNATURE | |
| Paul E. Kavanagh | | | | FEB 9 1982 | | | |



TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1- FOR
STATE
REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 2 0 3 8 0 8

REG. NO.

| | | | | | |
|--|--|---|---|--|--|
| 1. DECEASED NAME
(TYPE OR PRINT)
FIRST MIDDLE LAST
Willard Edward Harrison | | | 2a. DATE OF DEATH
MONTH DAY YEAR
02 05 82 | | 2b. HOUR
10:42P ^M |
| 3. SEX
male | 4. RACE
white | 5. DATE OF BIRTH
MONTH DAY YEAR
07 05 1909 | | 6. AGE (IN YEARS LAST BIRTHDAY)
72 YRS. | IF UNDER 1 YEAR
MONTHS DAYS HOURS MIN. |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
Maryland | 7b. CITIZEN OF WHAT COUNTRY?
USA | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
Baltimore CITY MD. | |
| 10. CITY OR TOWN OF DEATH
Baltimore | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
South Baltimore General Hosp. | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
A. Superintend. | | 12b. KIND OF BUSINESS OR INDUSTRY
oil Co. |
| 13a. STATE
MD | | | 13b. COUNTY
BALTIMORE | 13c. CITY OR TOWN
Baltimore | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
Joshua HARRISON | | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE
Bessie Steilkie | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)
No | | 16b. SOCIAL SECURITY NO.
068-05-7199 | | 17. INFORMANT
ADDRESS
Mary E. Harrison (same as 13e) | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART 1. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>CARDIO - pulmonary collapse</u>
<u>4279</u>
DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b) <u>ARRHYTHMIA</u>
DUE TO, OR AS A CONSEQUENCE OF
(c) _____
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input type="checkbox"/> | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK AT WORK | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>2/5</u> <u>1/14</u> 19 <u>82</u> , to <u>2/5</u> 19 <u>82</u> , that (I) (we) lost <u>above</u> <u>(I) (we) (did)</u> (did not) view the body after death. | | | | | |
| 22b. SIGNATURE
<u>Steven W. Eaton</u>
DEGREE | | | | 22c. DATE SIGNED
<u>2/6/82</u> | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
Steven W. Eaton MD. | | | | 22e. ADDRESS
3001 S. Hanover St. Baltimore MD. | |
| 23a. BURIAL, CREMATION, REMOVAL
(RECEIVED)
Burial | | 23b. DATE
2/9/82 | | 23c. NAME OF CEMETERY OR CREMATORY
Meadowridge Mem. | |
| 23d. LOCATION
CITY OR TOWN
Baltimore | | COUNTY
Md. | | STATE | |
| 24. FUNERAL DIRECTOR
NAME
Balto. Md. 21225
George J. Gonce F.H. 4001 Ritchie Hgwy. | | | | 25a. DATE REC'D. BY REGISTRAR
FEB 9 1982 | |
| | | | | 25b. REGISTRAR'S SIGNATURE
<u>James J. Nathan</u> | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

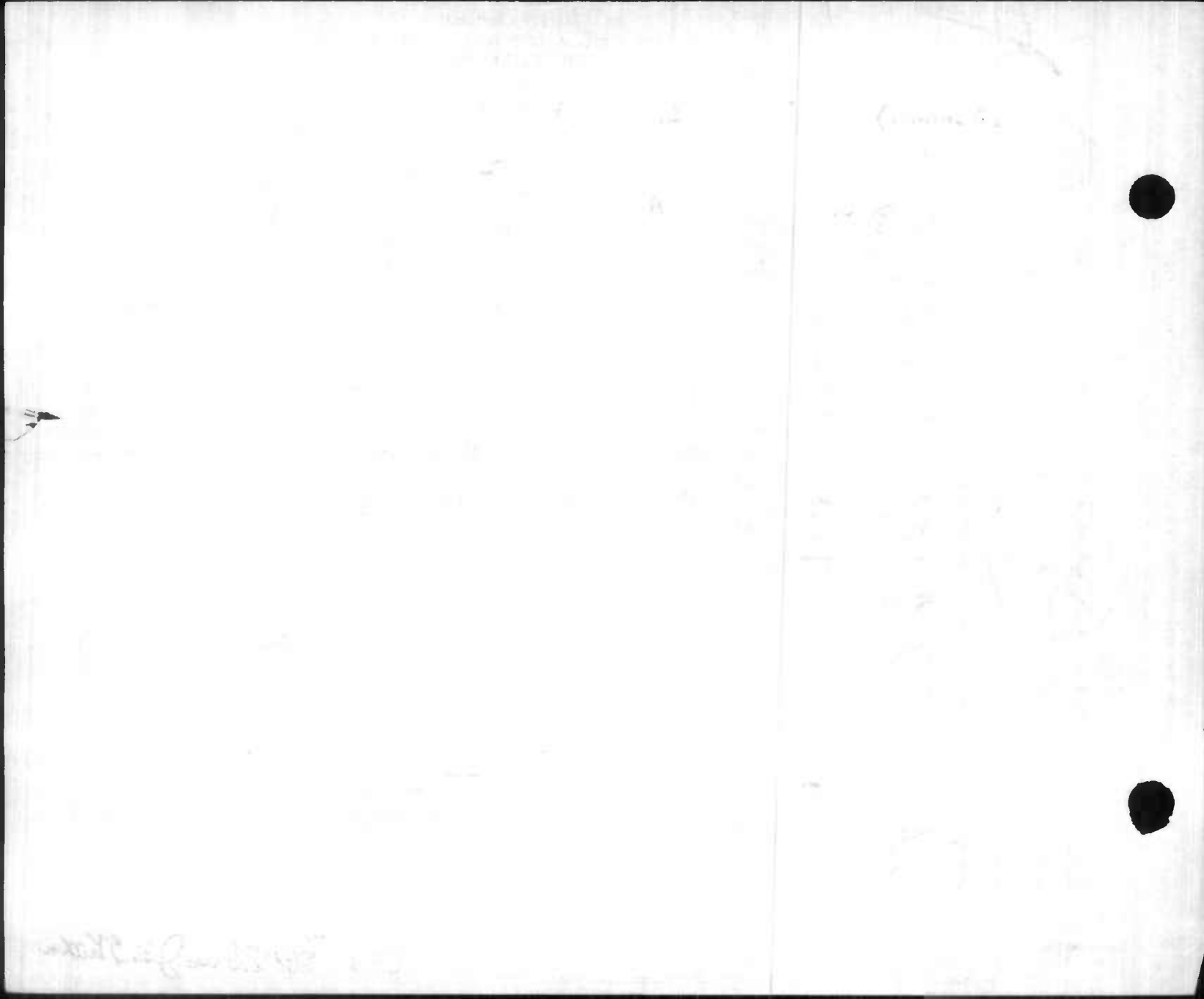
STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 2 0 3 8 0 9

1- FOR
STATE
REGISTRAR

REG. NO.

| | | | | | | | | | | |
|---|--|--|---|---|---|--|---|--|--|--|
| 1. DECEASED NAME
(TYPE OR PRINT) Johnnie L. HART | | | 2a. DATE OF DEATH
MONTH DAY YEAR
2 7 82 | | | 2b. HOUR
4:15 AM | | | | |
| 3. SEX
Male | | 4. RACE
Black | | 5. DATE OF BIRTH
MONTH DAY YEAR
1 12 23 | | 6. AGE (IN YEARS LAST BIRTHDAY)
59 | | 7. IF UNDER 1 YEAR
MONTHS DAYS HOURS MIN.
YRS. | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
S. C. | | 7b. CITIZEN OF WHAT COUNTRY?
USA | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
City MD. | | | | |
| 10. CITY OR TOWN OF DEATH
Baltimore | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
Sinai Hospital | | | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE) | | 12b. KIND OF BUSINESS OR INDUSTRY | | |
| 13a. STATE
Md | | | 13b. COUNTY
Balt. | | 13c. CITY OR TOWN
Balt. | | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS
8934 Annelier Rd | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
Hudson Hart | | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
Maggie Robinson | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN) No | | 16b. SOCIAL SECURITY NO.
249-24-3587 | | 17. INFORMANT ADDRESS
James Hart 912 N. Mount St. | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART 1. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Multiple organ disease
1629
DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b) Adenoca of the lung
DUE TO, OR AS A CONSEQUENCE OF
(c) _____ | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
WKS | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK AT WORK | | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from Feb 2nd 1982 to Feb 7 1982 , that (I) (we) lost
saw the deceased alive on Feb 6 1982 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated
above, (I) (we) (did) (do not) view the body after death. | | | | | | | | | | |
| 22b. SIGNATURE
W. Kellner | | | | | | DEGREE
ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> | | 22c. DATE SIGNED
2/7/82 | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
W. Kellner | | | | | | 22e. ADDRESS
Sinai Hospital | | | | |
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY) Burial | | | 23b. DATE
2/12/82 | | 23c. NAME OF CEMETERY OR CREMATORY
King Mem. Park | | 23d. LOCATION
CITY TOWN COUNTY STATE
Baltimore Co. MD | | | |
| 24. FUNERAL DIRECTOR
NAME ADDRESS
Wm. C. March F/H 1101 E. North Ave. | | | | | | 25a. DATE REC'D. BY REGISTRAR
FEB 9 1982 | | 25b. REGISTRAR'S SIGNATURE
Francis J. Kellner | | |



STATE OF MARYLAND

DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 2 - 0 3 8 1 0

REG. NO.

FOR
1. STATE
REGISTRAR

| | | | | | |
|--|---|---|---|---|---|
| 1. DECEASED NAME
(TYPE OR PRINT) BABY BOY HARTY | | | 2a. DATE OF DEATH MONTH 2 DAY 14 YEAR 82 | | 2b. HOUR 1:30 A.M. |
| 3 SEX Male | 4 RACE Black | 5. DATE OF BIRTH MONTH 2 DAY 13 YEAR 82 | | 6 AGE (IN YEARS LAST BIRTHDAY) YRS. 14 MONTHS 1 DAYS 14 MIN. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MARYLAND | 7b. CITIZEN OF WHAT COUNTRY? USA | 8 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9 BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE CITY MD. | |
| 10 CITY OR TOWN OF DEATH BALTIMORE | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) St Agnes Hospital | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) None | | 12b. KIND OF BUSINESS OR INDUSTRY |
| 13a. STATE Maryland | | | 13b. COUNTY Baltimore | 13c. CITY OR TOWN Baltimore | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |
| 14 FATHER'S NAME FIRST PERCIVAL MIDDLE HARTY | | | 15 MOTHER'S MAIDEN NAME FIRST CATHERINE MIDDLE WABB | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO | | | 16b. SOCIAL SECURITY NO. none | | 17 INFORMANT ADDRESS Mrs. Catharina Harty, 2443 E. Monument St. |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART 1. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Very Premature infant 24 wks
7670
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b) respiratory failure
(c) low intracranial hemorrhage | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: none | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | |
| 22a. I certify that (I) (this hospital) attended the deceased from 2/13 , 19 82 to 2/14 , 19 82 , that (I) (we) last saw the deceased alive on 2/14 , 19 82 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | |
| 22b. SIGNATURE Samuel R. Williams M.D. | | | | 22c. DATE SIGNED 2/14/82 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) SAMUEL R. Williams, M.D. | | | | 22e. ADDRESS St Agnes Hospital | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL | | 23b. DATE 3/4/82 | | 23c. NAME OF CEMETERY OR CREMATORY NEW CATHEDRAL 4300 OLD | |
| 23d. LOCATION FREDK. BALTO., MD. 21229 | | 23e. DATE REC'D. BY REGISTRAR 22 MAR 4 1982 | | | |
| 24 FUNERAL DIRECTOR NAME Witzke Fun'L Home, 1630 Edmondson Ave. | | 25a. DATE REC'D. BY REGISTRAR 22 MAR 4 1982 | | | |
| 25b. REGISTRAR'S SIGNATURE James J. Nathan | | | | | |

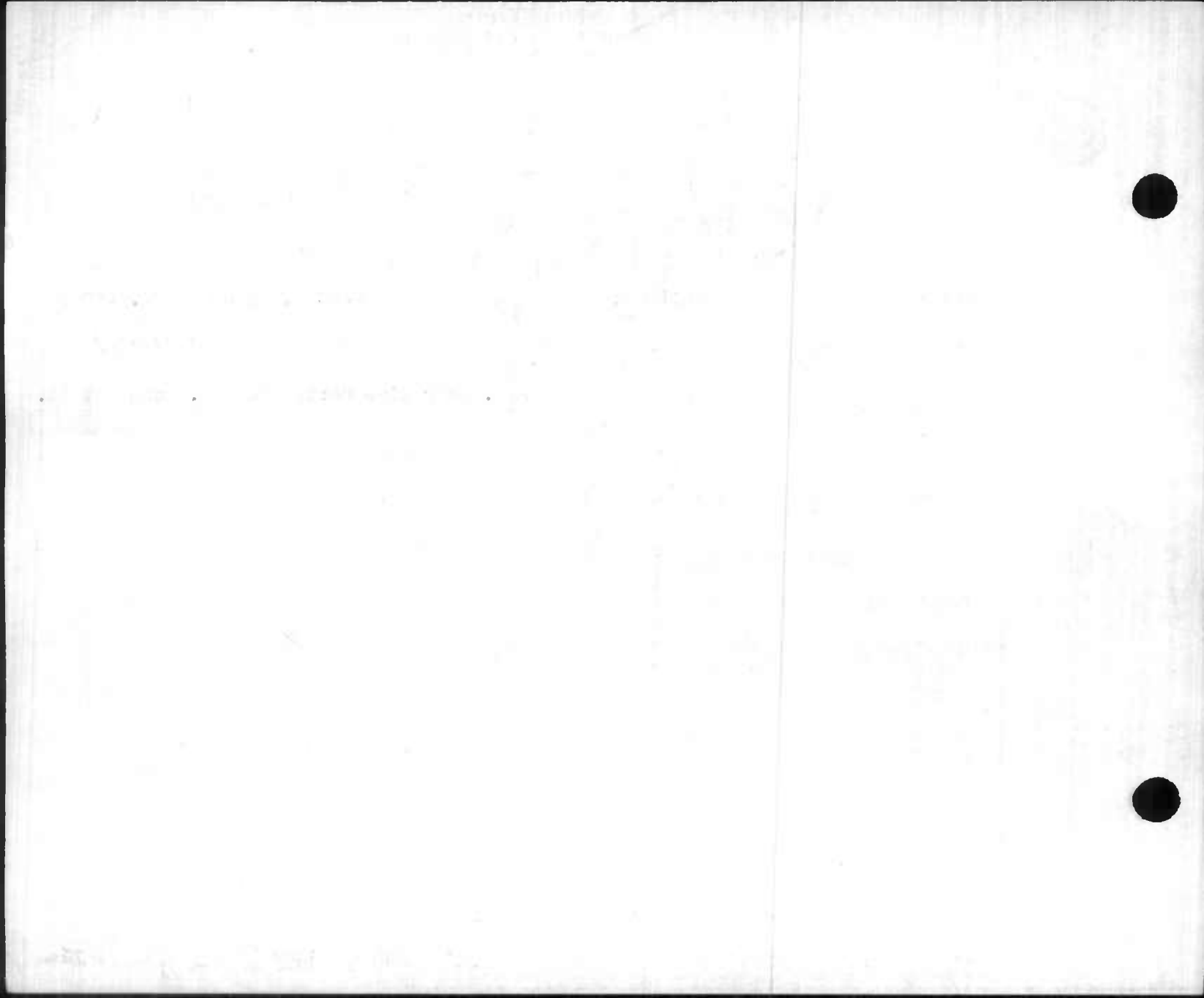
MEDICAL CERTIFICATION

2
9

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death and be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH | | | | 8 2 0 3 8 1 1 | | | |
|--|--|---|--|---|--|---|--|
| FOR
STATE
REGISTRAR | | | | REG. NO. | | | |
| 1. DECEASED NAME
(TYPE OR PRINT) <i>Willa A. Harvill</i> | | | | 2a. DATE OF DEATH
MONTH DAY YEAR <i>2-10-82</i> | | 2b. HOUR
<i>2:55 P.M.</i> | |
| 3. SEX
<i>Female</i> | | 4. RACE
<i>Black</i> | | 5. DATE OF BIRTH
MONTH DAY YEAR <i>1 2 12 08</i> | | 6. AGE (IN YEARS LAST BIRTHDAY)
<i>73</i> YRS. | |
| 7a. BIRTHPLACE
(COUNTRY) <i>Alabama</i> | | 7b. CITIZEN OF WHAT COUNTRY?
<i>U.S.</i> | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
<i>Baltimore City</i> MD. | |
| 10. CITY OR TOWN OF DEATH
<i>Baltimore</i> | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
<i>Lutheran Hospital</i> | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE) | | 12b. KIND OF BUSINESS OR INDUSTRY | |
| 13a. STATE
<i>MD</i> | | | | 13b. COUNTY | | 13c. CITY OR TOWN
<i>Baltimore</i> | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
<i>William Lovin Emma</i> | | | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
<i>Emma</i> | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN) | | 16b. SOCIAL SECURITY NO.
<i>213263990</i> | | 17. INFORMANT
ADDRESS
<i>Emogene Mitchell 1614 N. Ellamont St.</i> | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART 1. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <i>Cardiopulmonary arrest</i>
<i>1749</i>
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.
(b) <i>Metastatic cancer to the brain</i>
(c) <i>Possibly primary breast cancer</i> | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK AT WORK | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from <i>2/10/82</i> to <i>2/10/82</i> , that (I) (we) lost
saw the deceased alive on <i>2/10/82</i> and that in my (our) opinion death occurred on the date and hour and from the causes stated
above, (I) (we) (did) (did not) view the body after death. | | | | | | | |
| 22b. SIGNATURE
<i>K Yaw N Yunt</i> | | DEGREE | | ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | 22c. DATE SIGNED
<i>2/10/82</i> | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
<i>K YAW N YUNT</i> | | 22e. ADDRESS
<i>LUTHERAN HOSPITAL</i> | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY) <i>Burial</i> | | 23b. DATE
<i>2/16/82</i> | | 23c. NAME OF CEMETERY OR CREMATORY
<i>Western Star Cem</i> | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
<i>Baltimore Md.</i> | |
| 24. FUNERAL DIRECTOR
NAME
<i>Leroy O. Dpsta</i> | | ADDRESS
<i>4600 Liberty</i> | | 25a. DATE REC'D. BY REGISTRAR
<i>FEB 16 1982</i> | | 25b. REGISTRAR'S SIGNATURE
<i>Charles J. ...</i> | |

1607 BP

W. H. H. M.



See by 1874

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 2 0 3 8 1 2

1. FOR
STATE
REGISTRAR

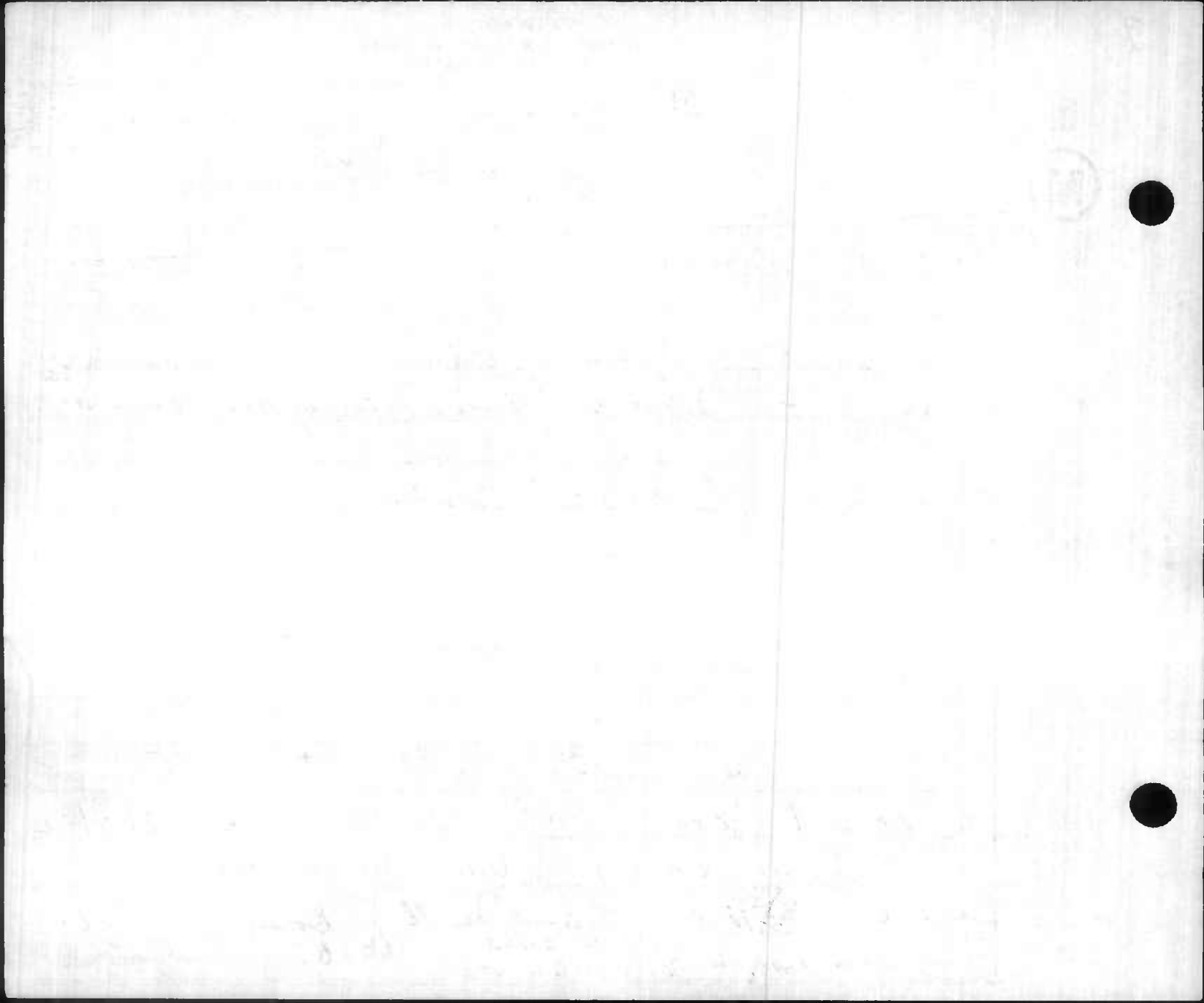
REG. NO.

| | | | | | | | | | |
|--|--|--|--|---|--|---|--|--|--|
| 1. DECEASED NAME
(TYPE OR PRINT) ELINOR M. HATHEWAY | | | | 2a. DATE OF DEATH
MONTH DAY YEAR
2-13-82 | | | | 2b. HOUR
1:50 P.M. | |
| 3. SEX
FEMALE | | 4. RACE
CAUCASIAN | | 5. DATE OF BIRTH
MONTH DAY YEAR
2 16 21 | | 6. AGE (IN YEARS LAST BIRTHDAY)
60 | | 7. IF UNDER 1 YEAR
MONTHS DAYS HOURS MIN. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
MD. | | 7b. CITIZEN OF WHAT COUNTRY?
USA. | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
BALTIMORE, MD. | | | |
| 10. CITY OR TOWN OF DEATH
BALTO. CITY | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
UNIVERSITY OF MD HOSP. | | | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
Clerk | | 12b. KIND OF BUSINESS OR INDUSTRY
Securix | |
| 13a. STATE
MD. | | 13b. COUNTY | | 13c. CITY OR TOWN
BALTO. | | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS
1153 CLEVELAND STREET | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
George E. Zobel | | | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
Eda Shawker | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
No | | 16b. SOCIAL SECURITY NO.
(IF YES, GIVE WAR OR DATES)
215-24-7606 | | 17. INFORMANT
ADDRESS
Albion Hatheway 1153 Cleveland St. 21230 | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART 1. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) ventricular fibrillation
4100
DUE TO, OR AS A CONSEQUENCE OF
(b) myocardial Infarction
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last
(c) _____
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
15 minutes | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) _____ | | | | | | | | | |
| 19a. DATE OF OPERATION | | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | | | | | | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER NOTIFY MEDICAL EXAMINER) | | | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | |
| 21d. INJURY OCCURRED
WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | | | 21e. PLACE OF INJURY
(AT HOME STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 2/12 , 19 82 , to 2/13 , 19 82 , that (I) (we) last saw the deceased alive on 2/13 , 19 82 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) did not view the body after death. | | | | | | | | | |
| 22b. SIGNATURE
Richard Carey | | | | DEGREE
MD | | | | 22c. DATE SIGNED
2/13/82 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
RICHARD CAREY | | | | 22e. ADDRESS
Univ. Md Hospital | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)
Burial | | 23b. DATE
2-18-1982 | | 23c. NAME OF CEMETERY OR CREMATORY
Greenwood Cem. Pl. | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
Dorsey Ind. | | | |
| 24. FUNERAL DIRECTOR
NAME
John Brown & Son, Inc. | | | | ADDRESS
901 Hallens St. | | 25a. DATE RECEIVED BY REGISTRAR
FEB 16 1982 | | 25b. REGISTRAR'S SIGNATURE
[Signature] | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be retained by the funeral director. Page 3 should be retained by the funeral director. Page 4 may be retained by the funeral director.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

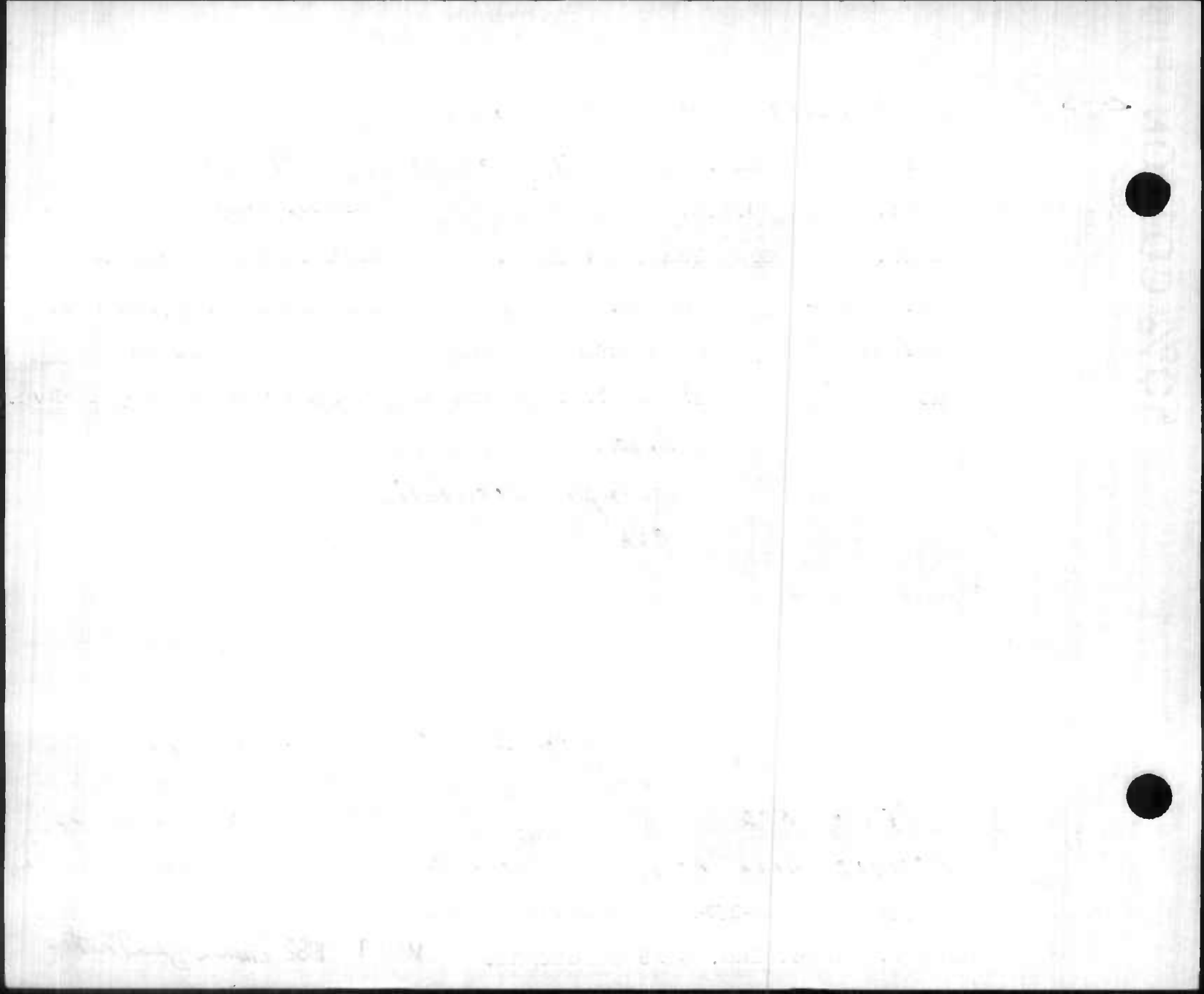
FOR
1 - STATE
REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 2 0 3 8 1 3

REG. NO.

| | | | | | | | | | |
|--|--|--|---|---|--|---|--|--|--|
| 1. DECEASED NAME
(TYPE OR PRINT)
CHARLES H HAWTHORNE | | | 2a. DATE OF DEATH
MONTH DAY YEAR
2 26 82 | | | 2b. HOUR
6:14 AM | | | |
| 3. SEX
Male | | 4. RACE
Cau. | | 5. DATE OF BIRTH
MONTH DAY YEAR
11 10 00 | | 6. AGE (IN YEARS LAST BIRTHDAY)
81 YRS | | 7. IF UNDER 1 YEAR
MONTHS DAYS
81 YRS | |
| 7a. BIRTHPLACE
(STATE OR FOREIGN COUNTRY)
Va. | | 7b. CITIZEN OF WHAT COUNTRY?
U.S.A. | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
Balto. City MD. | | | |
| 10. CITY OR TOWN OF DEATH
Balto. | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
Good Samaritan Hosp. | | | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
Balto. City | | 12b. KIND OF BUSINESS OR INDUSTRY
Retired | |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) | | | | | | | | | |
| 13a. STATE
Md. | | 13b. COUNTY
- | | 13c. CITY OR TOWN
Balto. | | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
Charles Hawthorne | | | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
Effie Brown | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)
no | | | | 16b. SOCIAL SECURITY NO.
212-26-1171 | | 17. INFORMANT
ADDRESS
Howard Sawyer 5813 Benton Heights Ave. | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART 1. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Septic
4360
DUE TO, OR AS A CONSEQUENCE OF
(b) Multiple Decubiti
DUE TO, OR AS A CONSEQUENCE OF
(c) CVA
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) | | | | | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from Feb 2 , 19 82 , to Feb 26 , 19 82 , that (I) (we) last saw the deceased alive on Feb 25 , 19 82 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | |
| 22b. SIGNATURE
Rita Rose | | | | DEGREE
ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> | | | | 22c. DATE SIGNED
2-26-82 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
ROMULO DELA ROSA | | | | 22e. ADDRESS
Good Samaritan Hosp. - Baltimore Md. | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)
Burial | | 23b. DATE
2-27-82 | | 23c. NAME OF CEMETERY OR CREMATORY
Lorraine Cem. | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
Balto Md. | | | |
| 24. FUNERAL DIRECTOR
NAME ADDRESS
John C. Miller Inc. 6415 Belair Rd. | | | | 25a. DATE REC'D. BY REGISTRAR
MAR 1 1982 | | | | | |
| | | | | 25b. REGISTRAR'S SIGNATURE
James Santhorn | | | | | |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

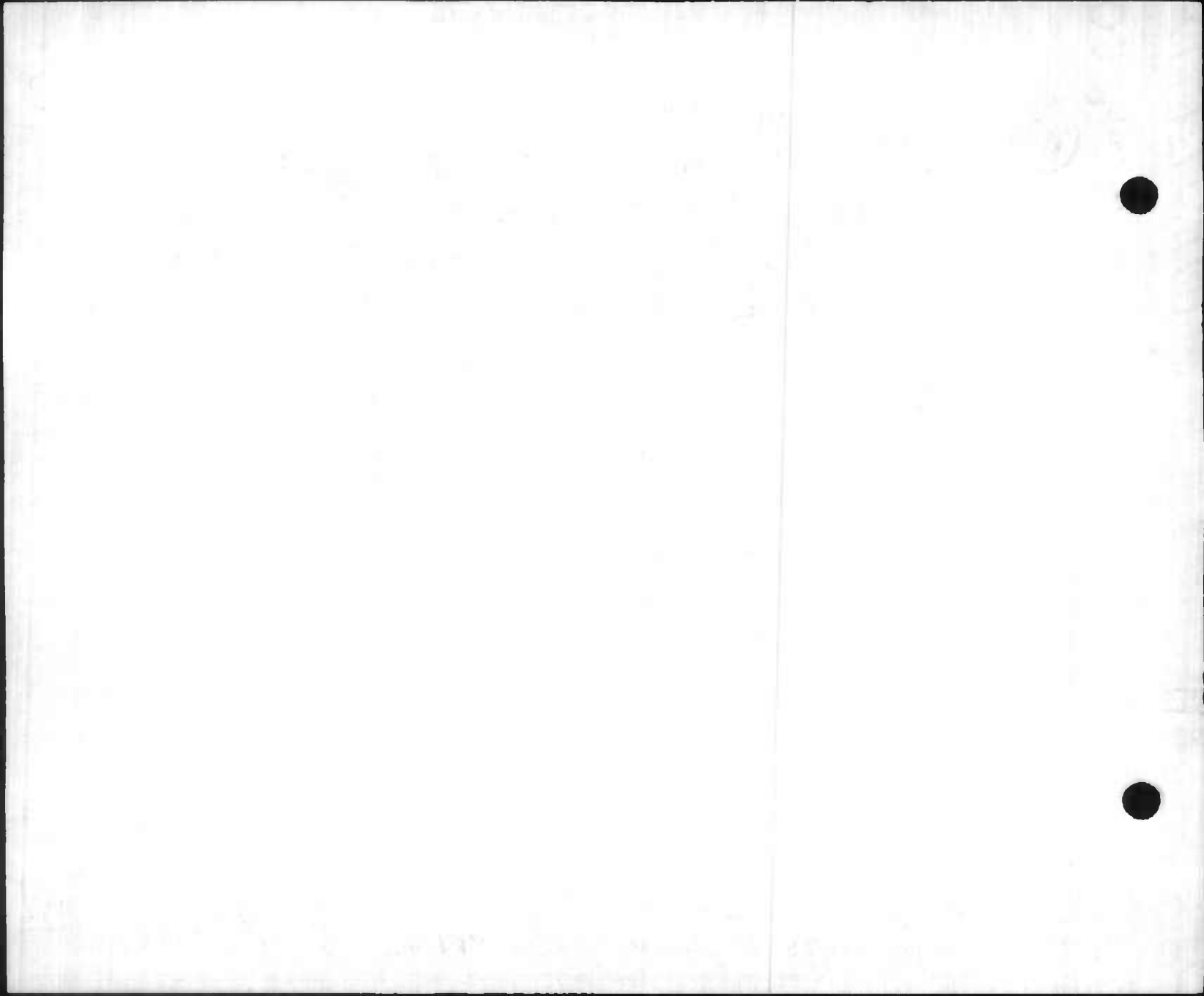
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 24 hours with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

| STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE | | | | 8 2 0 3 8 1 4 | | | |
|--|--|--|--|--|--|--|--|
| FOR
1 - STATE
REGISTRAR | | | | REG. NO. | | | |
| 1 DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST
Dennis NMN Hawkins | | | | 2a DATE OF DEATH MONTH DAY YEAR
2-24-82 | | 2b HOUR ¹⁰
6 P M | |
| 3 SEX
M | | 4 RACE
B | | 5 DATE OF BIRTH MONTH DAY YEAR
Apr 6-1905 | | 6 AGE (IN YEARS LAST BIRTHDAY) ⁷⁶
76 YRS. | |
| 7a BIRTH PLACE (STATE OR FOREIGN COUNTRY)
Md | | 7b CITIZEN OF WHAT COUNTRY?
U.S.A. | | 8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9 BALTIMORE CITY OR COUNTY OF DEATH
Baltimore City MD. | |
| 10 CITY OR TOWN OF DEATH
Baltimore | | 11 NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
Provident Hospital | | 12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)
Truck Driver | | 12b KIND OF BUSINESS OR INDUSTRY | |
| 13a USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) STATE COUNTY CITY OR TOWN
Md ANNAPOLIS | | | | 13b INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13c STREET ADDRESS
432 Chesapeake Ave | |
| 14 FATHER'S NAME FIRST MIDDLE LAST
Henry Hawkins | | 15 MOTHER'S MAIDEN NAME FIRST LAST
Loucrecy Murdock | | | | | |
| 16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)
No | | 16b SOCIAL SECURITY NO. | | 17 INFORMANT ADDRESS
Rebecca Gilchrist Saye As 13E | | | |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Bronchogenic Ca with metastasis
1629
DUE TO, OR AS A CONSEQUENCE OF (b) _____
DUE TO, OR AS A CONSEQUENCE OF (c) _____
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) _____ | | | | | | | |
| 19a DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | |
| 21d INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21e PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f LOCATION STREET CITY OR TOWN COUNTY STATE | | | |
| 22a I certify that (I) (this hospital) attended the deceased from 2-5-82 to 2-24-82 , that (I) (we) last saw the deceased alive on 2-24-82 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death. | | | | | | | |
| 22b SIGNATURE
H. Devados | | DEGREE M.D. ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | 22c DATE SIGNED
2-24-82 | | | |
| 22d PHYSICIAN'S NAME (TYPE OR PRINT)
H. Devados | | 22e ADDRESS
Provident Hospital | | | | | |
| 23a BURIAL, CREMATION, REMOVAL (SPECIFY)
BURIAL | | 23b DATE
MAR 2-82 | | 23c NAME OF CEMETERY OR CREMATORY
PINE LAWN | | 23d LOCATION CITY OR TOWN COUNTY STATE
ANNAPOLIS MD | |
| 24 FUNERAL DIRECTOR NAME
C.E. Hicks | | ADDRESS
ANNAPOLIS MD | | DATE REC'D. BY REGISTRAR
MAR 8 1982 | | | |

BP



STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 2 0 3 8 1 5

1. FOR
STATE
REGISTRAR

REG. NO.

| | | | | | |
|---|--|---|--|---|---|
| 1. DECEASED NAME
(TYPE OR PRINT) Harold P. Hayley Sr. | | | 2a. DATE OF DEATH
MONTH DAY YEAR
02 01 82 | | 2b. HOUR
M
M |
| 3. SEX
Male | 4. RACE
Black | 5. DATE OF BIRTH
MONTH DAY YEAR
10 12 21 | | 6. AGE (IN YEARS LAST BIRTHDAY)
60 | IF UNDER 1 YEAR
MONTHS DAYS
IF UNDER 24 HRS
HOURS MIN. |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
N.C. | 7b. CITIZEN OF WHAT COUNTRY?
USA | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
Baltimore MD. | |
| 10. CITY OR TOWN OF DEATH
Baltimore | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
Provident Hospital | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE) | | 12b. KIND OF BUSINESS OR INDUSTRY |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)
13a. STATE MD 13b. COUNTY | | | 13c. CITY OR TOWN
Baltimore | | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
Walter E. Hayley | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
Alice Hairston | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)
Yes | | 16b. SOCIAL SECURITY NO.
242-26-4529 | | 17. INFORMANT
ADDRESS
Catherine L. Hayley 2045 Braddish Av | |

| | | |
|--|--|--|
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART 1. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Cardiac arrest
4275
DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last
(b) Acute Respiratory Failure
DUE TO, OR AS A CONSEQUENCE OF
(c) | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
|--|--|--|

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 11a:

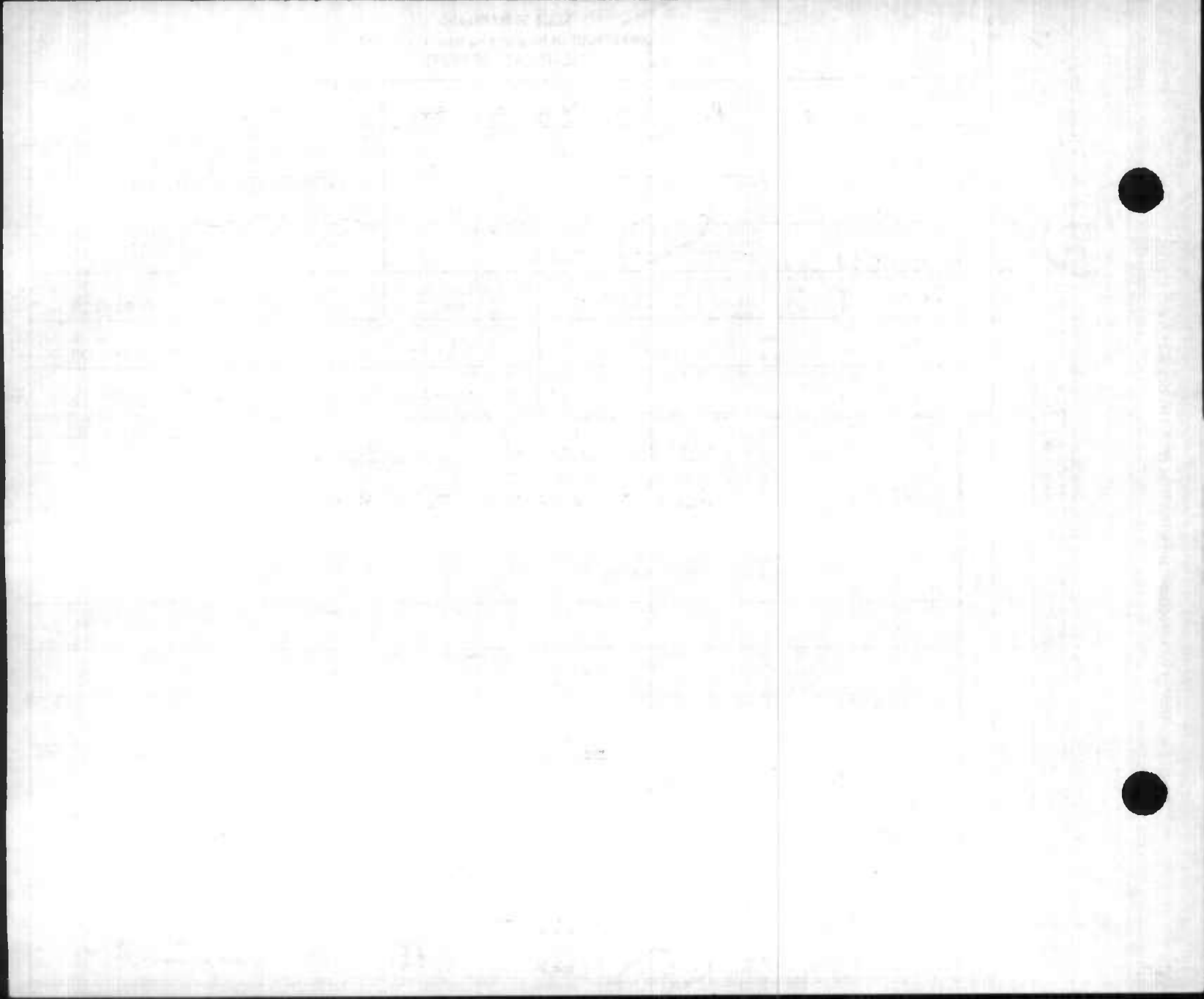
| | | | | | |
|--|--|--|--|---|--|
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input type="checkbox"/> | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from Jan 31 , 19 82 , to Feb 1 , 19 82 , that (I) (we) last saw the deceased alive on Feb 1 , 19 82 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | |
| 22b. SIGNATURE
D. Bell, M.D. | | DEGREE
ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> | | | 22c. DATE SIGNED
2-1-82 |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
D. Bell, M.D. | | 22e. ADDRESS
2600 Liberty Heights | | | |

| | | | |
|--|----------------------------|---|---|
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)
Burial | 23b. DATE
2/8/82 | 23c. NAME OF CEMETERY OR CREMATORY
Md. Veteran Cem | 23d. LOCATION
CITY OR TOWN COUNTY STATE
Crownsville MD |
| 24. FUNERAL DIRECTOR
NAME ADDRESS
Wm. C. March F/H 1101 E. North Ave. | | 25a. DATE REC'D. BY REGISTRAR 25b. REGISTRAR'S SIGNATURE
FEB 3 1982 [Signature] | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be kept for 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

(IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.)



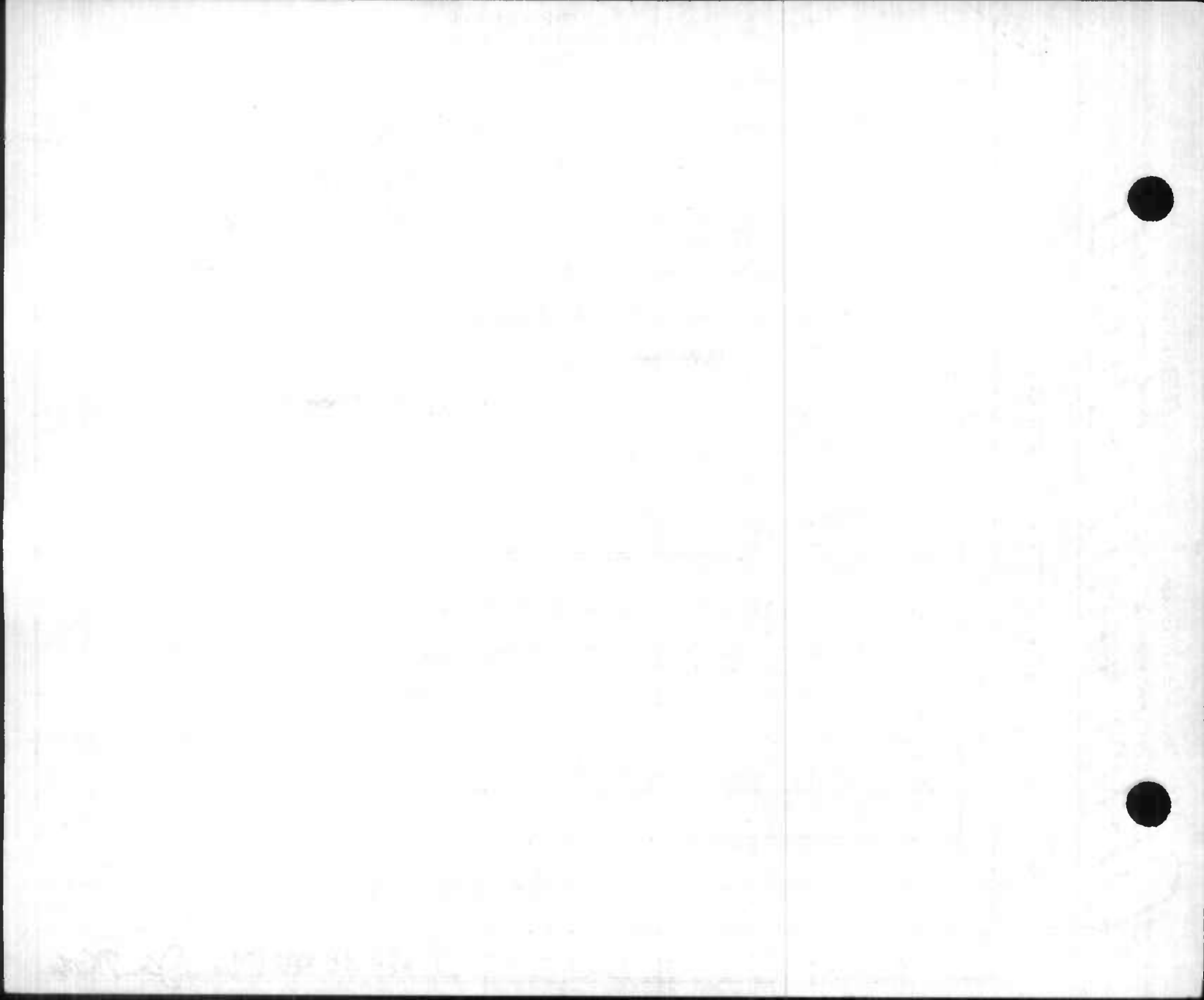
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.FOR
1 - STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

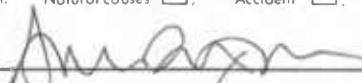

8 2 0 3 8 1 6

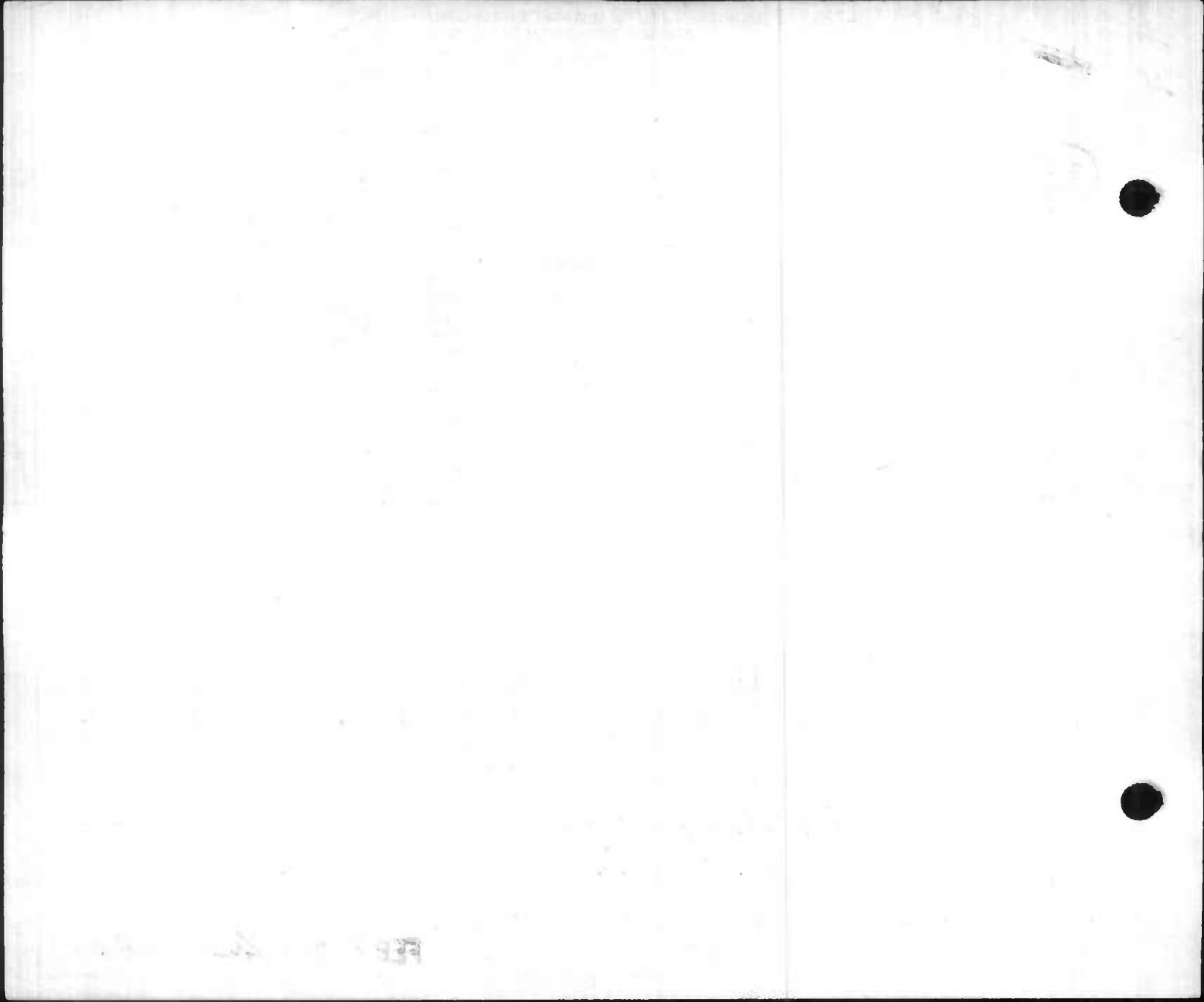
REG. NO.

| | | | | | | | | | |
|--|--|--|--|---|--|---|--|--|--|
| 1. DECEASED NAME
(TYPE OR PRINT)
Steven Hayward | | | 2a. DATE OF DEATH
MONTH DAY YEAR
2-25-82 | | | 2b. HOUR
25
4 ²⁵ A.M. | | | |
| 3. SEX
Male | | 4. RACE
Black | | 5. DATE OF BIRTH
MONTH DAY YEAR
5 5 36 | | 6. AGE (IN YEARS LAST BIRTHDAY)
45 YRS | | IF UNDER 1 YEAR
MONTHS DAYS
IF UNDER 24 HRS
HOURS MIN. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
MD | | 7b. CITIZEN OF WHAT COUNTRY?
USA | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
City MD. | | | |
| 10. CITY OR TOWN OF DEATH
Baltimore | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
Lutheran Hospital | | | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE) | | 12b. KIND OF BUSINESS OR INDUSTRY | |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) | | | | | | | | | |
| 13a. STATE
MD | | 13b. COUNTY | | 13c. CITY OR TOWN
Baltimore | | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS
1800 Eutaw Place | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
Jack Hayward | | | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
Aline Porter | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN) [IF YES, GIVE WAR OR DATES]
Yes | | | | 16b. SOCIAL SECURITY NO.
213-24-3348 | | 17. INFORMANT
ADDRESS
Earther L. Hayward 1403 E. Lanvale | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART 1. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>Cerebral vascular accident</u>
4360
DUE TO, OR AS A CONSEQUENCE OF
(b) _____
DUE TO, OR AS A CONSEQUENCE OF
(c) _____
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) | | | | | | | | | |
| 19a. DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK | | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>1/15</u> , 19 <u>82</u> , to <u>2/25</u> , 19 <u>82</u> , that (I) (we) last saw the deceased alive on <u>2/25</u> , 19 <u>82</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | |
| 22b. SIGNATURE
<u>Hermin J. Sacerno, M.D.</u> | | | | | DEGREE
ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> | | | 22c. DATE SIGNED
2/25/82 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) | | | | | 22e. ADDRESS | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)
Burial | | | 23b. DATE
3/2/82 | | 23c. NAME OF CEMETERY OR CREMATORY
Md. Veteran Cem. | | 23d. LOCATION
CITY OR TOWN COUNTY
Crownsville MD | | |
| 24. FUNERAL DIRECTOR
NAME
Wm. C. March F/H 1101 E. North Ave. | | | | | 25a. DATE REC'D. BY REGISTRAR
FEB 26 1982 | | 25b. REGISTRAR'S SIGNATURE
<u>James J. Nathan</u> | | |



TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 1 AND 2 FOR THE DIVISION OF VITAL RECORDS. PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED AFTER DEATH. WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

| STATE #18a-22a Film G566 L46/82 STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH | | | | | | | | | | REG. NO. 2 0 3 8 1 7 | | | |
|--|--|------------------|--|---|--|---|--|---|--|--|--|-----------------------------------|--|
| 1- STATE REGISTRAR | | | | | | | | | | | | | |
| 1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST
JEFFERY L. HAYWOOD | | | | | | | | | | 2a. DATE KNOWN OF DEATH ESTIMATED <input checked="" type="checkbox"/> MONTH DAY YEAR
2 18 19 82 | | 2b. HOUR
M | |
| 3. SEX
male | | 4. RACE
negro | | 5. DATE OF BIRTH MONTH DAY YEAR
8 6 56 | | 6. AGE (IN YEARS LAST BIRTHDAY) 25 YRS. | | IF UNDER 1 YR. MONTHS DAYS
IF UNDER 24 HRS. HOURS MIN. | | 2c. DATE PRONOUNCED DEAD
2 18 19 82 | | 2d. HOUR
7a M | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
MD | | | | 7b. CITIZEN OF WHAT COUNTRY?
USA | | | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
Baltimore City MD. | | | |
| 10. CITY OR TOWN OF DEATH
Baltimore | | | | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
(street) 3333 Windsor Ave. | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | | | | 12b. KIND OF BUSINESS OR INDUSTRY | |
| USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) | | | | | | | | | | | | | |
| 13a. STATE
MD | | 13b. COUNTY
✓ | | 13c. CITY OR TOWN
Baltimore | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS
2235 N. Ellamont | | | | | |
| 14. FATHER'S NAME FIRST MIDDLE LAST
James L. Haywood | | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST
Frances Mills | | | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)
Yes | | | | 16b. SOCIAL SECURITY NO.
213-64-5070 | | 17. INFORMANT ADDRESS
Frances Haywood 2235 N. Ellamont | | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>Hypothermia</u>
DUE TO, OR AS A CONSEQUENCE OF
(b) _____
DUE TO, OR AS A CONSEQUENCE OF
(c) _____
Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause lost. | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) | | | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | | | | | | 20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH | | | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR
? P.M. 2/18/ 19 82 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)
Exposure to cold | | | | | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK AT WORK | | | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)
street | | 21f. LOCATION CITY OR TOWN STATE
3333 Windsor Ave. Baltimore Md. | | | | | | | |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> . | | | | | | | | | | | | | |
| ACTUAL SIGNATURE  | | | | TITLE (SPECIFY)
M.D. Assistant MEDICAL EXAMINER | | | | DATE SIGNED 2-18-82 | | | | | |
| EXAMINER'S NAME (TYPE OR PRINT)
Ann M. Dixon, M.D. | | | | ADDRESS
111 Penn St. | | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)
Burial | | | | 23b. DATE
2/24/82 | | 23c. NAME OF CEMETERY OR CREMATORY
Md. Veteran Cem. | | | | 23d. LOCATION CITY OR TOWN COUNTY STATE
Crownsville MD | | | |
| 24. FUNERAL DIRECTOR NAME
Wm. C. March F/H 1101 E. North Ave. | | | | | | 25a. DATE REC'D. BY REGISTRAR
FEB 23 1982 | | 25b. REGISTRAR'S SIGNATURE
 | | | | | |



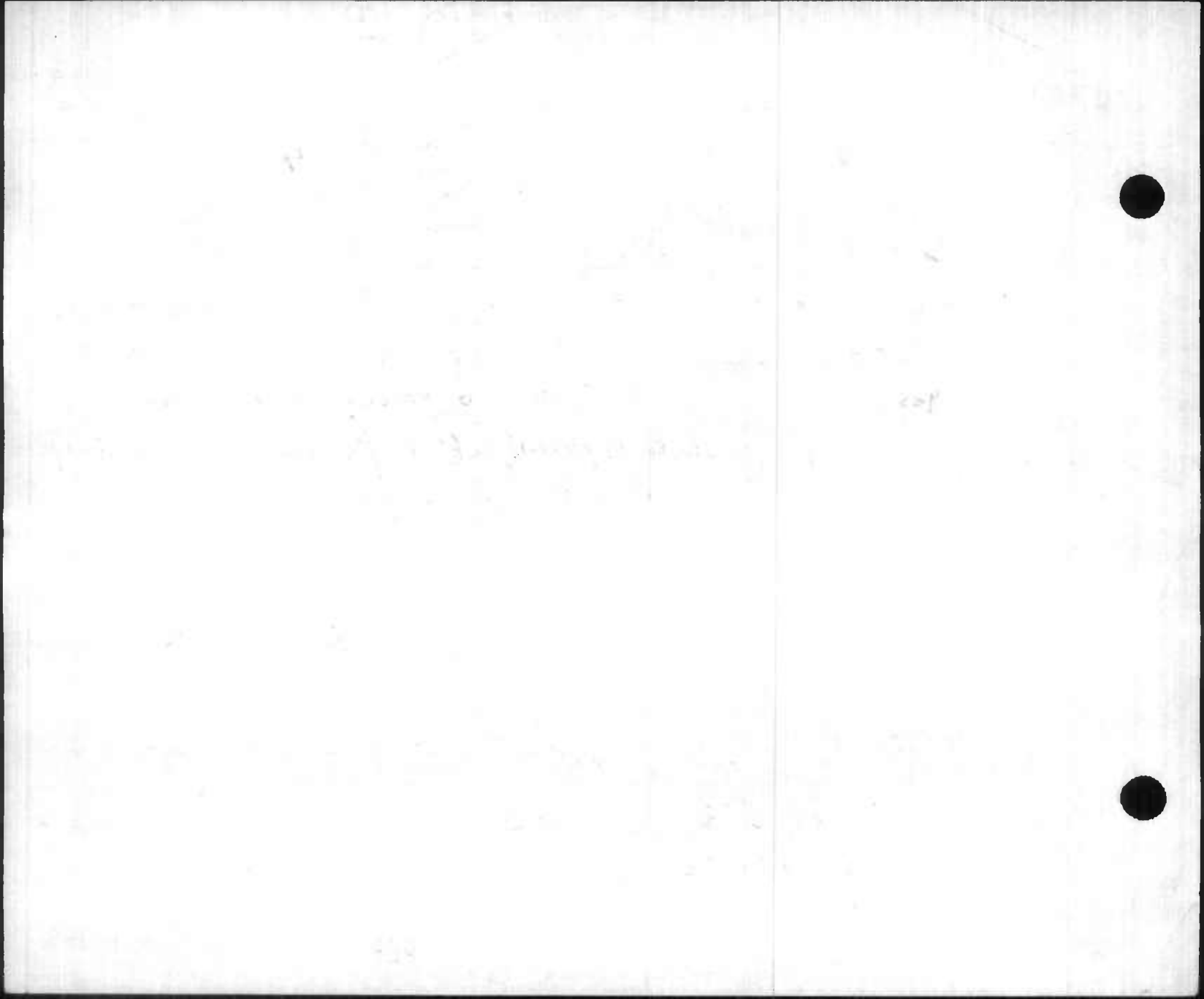
STATE OF MARYLAND

DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 2 0 3 8 1 8

REG. NO.

| | | | | | | | |
|--|-------------------------------------|---|--|---|--|--|--|
| 1. FOR STATE REGISTRAR | | 2a. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST
CORROTHER - HEADEN | | 2b. DATE OF DEATH MONTH DAY YEAR
2 20 82 | | 2c. HOUR
6 A M | |
| 3. SEX
✓ M | 4. RACE
B | 5. DATE OF BIRTH MONTH DAY YEAR
12 15 07 | | 6. AGE (IN YEARS LAST BIRTHDAY) YRS
74 | | IF UNDER 1 YEAR MONTHS DAYS
IF UNDER 24 HRS HOURS MIN. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
M.C. | 7b. CITIZEN OF WHAT COUNTRY?
USA | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
Balt. City MD. | | | |
| 10. CITY OR TOWN OF DEATH
Balt. | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
SBGH | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)
Amer. Transfer | | 12b. KIND OF BUSINESS OR INDUSTRY | |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE
md | | 13b. COUNTY
Balt | | 13c. CITY OR TOWN
Balt | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 14. FATHER'S NAME FIRST MIDDLE LAST
ZEB | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST
NANCY PRICE | | 13e. STREET ADDRESS
716 Roundview ave. | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)
yes | | 16b. SOCIAL SECURITY NO.
217 052341 | | 17. INFORMANT ADDRESS
Della Headen 716 Roundview Rd. | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART 1. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>Acute myocardial Infarction</u>
4100
DUE TO, OR AS A CONSEQUENCE OF (b) <u>A.S.C.V.D.</u>
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last
DUE TO, OR AS A CONSEQUENCE OF (c)
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
5 days | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | |
| 22a. I certify that (1) (this hospital) attended the deceased from <u>2/15</u> 19 <u>82</u> to <u>2/20</u> 19 <u>82</u> that (1) (we) lost saw the deceased alive on <u>2/20</u> 19 <u>82</u> and that in my (our) opinion death occurred on the date and hour and from the causes stated above, (1) (we) (did) (did not) view the body after death. | | | | | | | |
| 22b. SIGNATURE
S. Hallick | | DEGREE
MD | | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> | | 22c. DATE SIGNED
2/20/82 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
GALEN HALLICK | | 22e. ADDRESS
3001 S. HANOVER ST. | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)
Burial | | 23b. DATE
2/25/82 | | 23c. NAME OF CEMETERY OR CREMATORY
Md. Veteran Cem. | | 23d. LOCATION CITY OR TOWN COUNTY
Crownsville MD | |
| 24. FUNERAL DIRECTOR NAME
Wm. C. March F/H | | | | ADDRESS
1101 E. North Ave. | | 25a. DATE REC'D BY REGISTRAR
FEB 22 1982 | |



TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 24 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.



| STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH | | | | | | | | | | REG. NO. 2 0 3 8 1 9 | |
|--|--|------------------|--|--|--|---|--|---|--|---|--|
| 1. FOR STATE REGISTRAR | | | | | | | | | | | |
| 1. DECEASED NAME
(TYPE OR PRINT) FIRST MIDDLE LAST
EMMA D. HEBB | | | | | | 2a. DATE KNOWN OF DEATH
ESTIMATED MONTH DAY YEAR
<input checked="" type="checkbox"/> 2 3 19 82 | | 2b. HOUR
M
7:21 P M | | | |
| 3. SEX
female | | 4. RACE
negro | | 5. DATE OF BIRTH
MONTH DAY YEAR
2 21 22 | | 6. AGE (IN YEARS)
(BIRTHDAY) YRS.
59 | | IF UNDER 1 YR. MONTHS DAYS
IF UNDER 24 HRS. HOURS MIN. | | 2c. DATE PRONOUNCED DEAD
MONTH DAY YEAR
2 3 19 82 | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
MD | | | | 7b. CITIZEN OF WHAT COUNTRY?
USA | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
Baltimore City MD | | | |
| 10. CITY OR TOWN OF DEATH
Baltimore | | | | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
2754 W. Mosher St. | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | | 12b. KIND OF BUSINESS OR INDUSTRY | |
| 13a. STATE
MD | | | | 13b. COUNTY | | 13c. CITY OR TOWN
Baltimore | | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS
2754 Mosher St. | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
Paul Saxon | | | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
Bessie Bible | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO, OR UNKNOWN) (IF YES, GIVE WAR OR DATES)
No | | | | 16b. SOCIAL SECURITY NO.
215-18-6870 | | 17. INFORMANT ADDRESS
John A. Hebb 2754 Mosher St. | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>Arteriosclerotic cardiovascular disease</u>
4292 } DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which }
gave rise to immediate }
cause (a) stating the under- }
lying cause last. } (b) }
DUE TO, OR AS A CONSEQUENCE OF }
(c) } | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a). | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | | | | | | 20. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 21a. EXTERNAL CAUSE WAS
UNDERLYING <input type="checkbox"/> OR
CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH | | | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) | | | | | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK AT WORK | | | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | | | |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> . | | | | | | | | | | | |
| ACTUAL SIGNATURE
 | | | | TITLE (SPECIFY)
M.D. Assistant | | | | DATE SIGNED
2-4-82 | | | |
| EXAMINER'S NAME
(TYPE OR PRINT)
Ann M. Dixon, M.D. | | | | ADDRESS
111 Penn St. | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)
Burial | | | | 23b. DATE
2/8/82 | | 23c. NAME OF CEMETERY OR CREMATORY
Md. Veteran Cem. | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
Crownsville MD | | | |
| 24. FUNERAL DIRECTOR
NAME
Wm. C. March F/H | | | | | | ADDRESS
1101 E. North Ave. | | 25a. DATE REC'D. BY REGISTRAR
FEB 5 1982 | | 25b. REGISTRAR'S SIGNATURE
 | |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

MEDICAL CERTIFICATION

| STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH | | | | REG. NO. 8 2 0 3 8 2 0 | |
|--|--|--|----------------------------------|--|--|
| 1. FOR STATE REGISTRAR | | | 1. DECEASED NAME | | |
| FIRST MIDDLE LAST | | | 2a. DATE OF DEATH MONTH DAY YEAR | | |
| BLANCHE E. HEIMILLER | | | February 3, 1982 | | |
| 2b. HOUR | | | 1000 P M | | |
| 3. SEX | | 4. RACE | | 5. DATE OF BIRTH | |
| Female | | White | | MONTH DAY YEAR | |
| | | | | Jan. 12, 1898 | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) | | 7b. CITIZEN OF WHAT COUNTRY? | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> | |
| Maryland | | USA | | WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | |
| 10. CITY OR TOWN OF DEATH | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) | | 9. BALTIMORE CITY OR COUNTY OF DEATH | |
| Baltimore | | 4436 Wrenwood Avenue | | Baltimore City MD. | |
| 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | | 12b. KIND OF BUSINESS OR INDUSTRY | | | |
| Homemaker | | Own Home | | | |
| 13a. STATE | | | 13b. COUNTY | | |
| Baltimore | | | Baltimore | | |
| 14. FATHER'S NAME | | | 15. MOTHER'S MAIDEN NAME | | |
| FIRST MIDDLE LAST | | | FIRST MIDDLE LAST | | |
| Thomas W. Griffin | | | Margaret Miller | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) | | | 16b. SOCIAL SECURITY NO. | | |
| No | | | 220 01 4440 | | |
| 17. INFORMANT | | | ADDRESS | | |
| Cameron J. Heimiller, Balto., Md. | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) | | | | | |
| PART I. DEATH WAS CAUSED BY: | | | | | |
| IMMEDIATE CAUSE (a) <u>Heart Failure</u> | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF (b) <u>ASH D</u> | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF (c) <u>years</u> | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? | |
| | | | | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) | |
| | | P.M. 19 | | | |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION CITY OR TOWN COUNTY STATE | |
| | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>Nov 16</u> , 19 <u>81</u> , to <u>Nov 81</u> , 19 <u>81</u> , that (I) (we) last saw the deceased alive on <u>Nov 81</u> , 19 <u>81</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did not) view the body after death. | | | | | |
| 22b. SIGNATURE | | DEGREE | | 22c. DATE SIGNED | |
| <u>Philip L. Wagley</u> | | M.D. | | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) | | 22e. ADDRESS | | | |
| Dr. Philip L. Wagley, M.D. | | 9 E. Chase St., Balto., Md. 21202 | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) | | 23b. DATE | | 23c. NAME OF CEMETERY OR CREMATORY | |
| Burial | | 2/6/82 | | Lorraine Park | |
| | | | | Balto., Md. STATE | |
| 24. FUNERAL DIRECTOR NAME | | 24b. ADDRESS | | 25a. DATE REC'D. BY REGISTRAR | |
| Henry W. Jenkins & Sons Co. | | 4905 York Road Balto., Md. 21212 | | FEB 4 1982 | |
| | | | | 25b. REGISTRAR'S SIGNATURE | |
| | | | | <u>Thomas J. Jenkins</u> | |



1. The first part of the document is a letter from the Secretary of the State Department to the President, dated January 1, 1941. The letter discusses the situation in Europe and the need for a strong defense.

2. The second part of the document is a report from the Joint Chiefs of Staff, dated January 1, 1941. The report discusses the military situation and the need for a strong defense.

3. The third part of the document is a report from the War Relocation Authority, dated January 1, 1941. The report discusses the situation of Japanese-Americans and the need for a strong defense.

4. The fourth part of the document is a report from the War Relocation Authority, dated January 1, 1941. The report discusses the situation of Japanese-Americans and the need for a strong defense.

5. The fifth part of the document is a report from the War Relocation Authority, dated January 1, 1941. The report discusses the situation of Japanese-Americans and the need for a strong defense.

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM-3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP

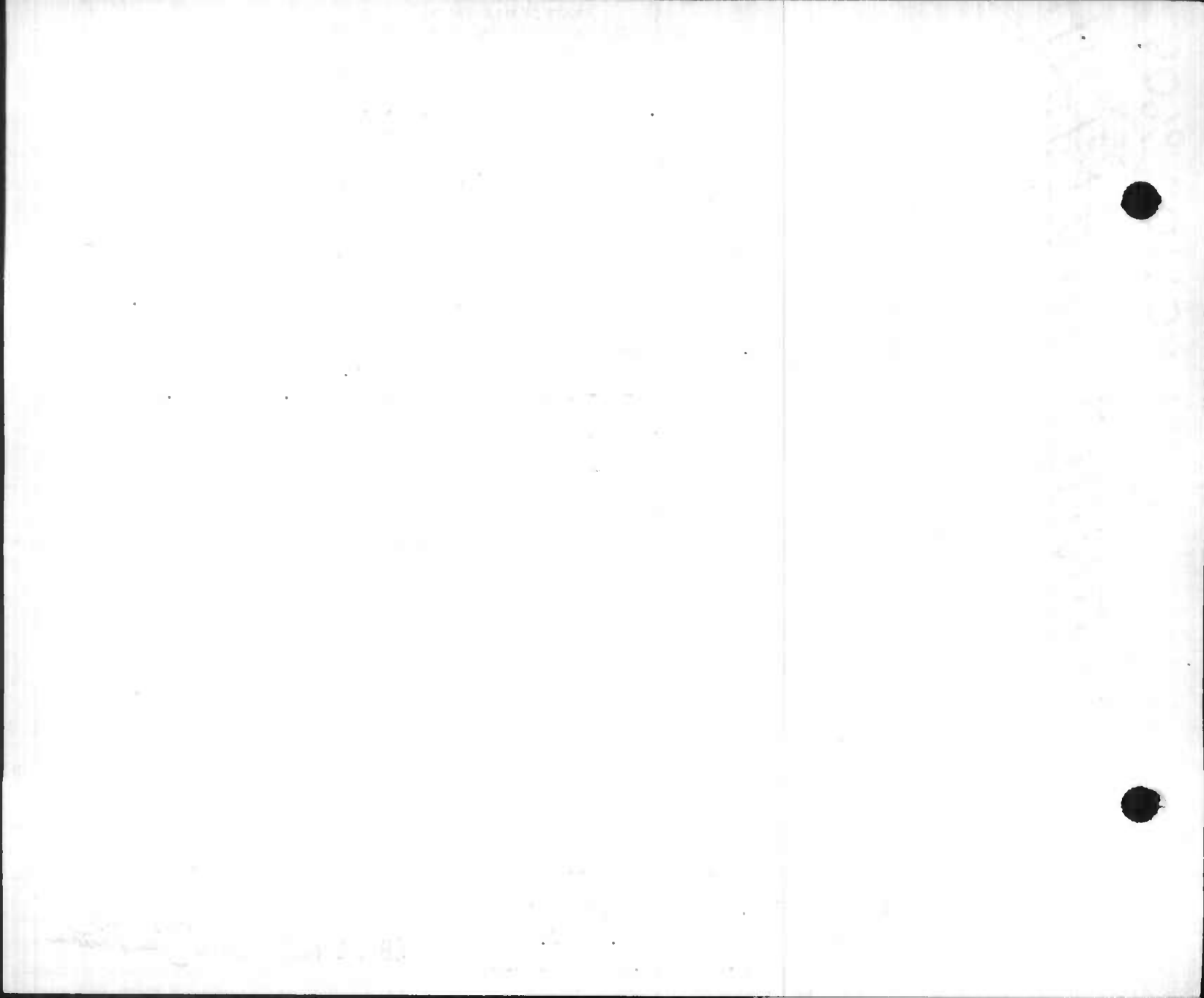
DHMH - 17
(VR A15 ME (1))
15M2/80

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

FOR
STATE
REGISTRAR

| | | | | | | | | |
|--|------------------|--|---|---|---|---|---|---|
| 1. DECEASED NAME
(TYPE OR PRINT)
Richard H. Heller, M.D. | | | 2a. DATE KNOWN OF DEATH
ESTIMATED
MONTH DAY YEAR
2 7 19 82 | | | 2b. HOUR
M
4:20 PM | | |
| 3. SEX
male | 4. RACE
white | 5. DATE OF BIRTH
MONTH DAY YEAR
JUNE 5, 1938 | 6. AGE (IN YEARS)
(LAST BIRTHDAY)
43 YRS. | IF UNDER 1 YR.
MONTHS DAYS | IF UNDER 24 HRS.
HOURS MIN | 2c. DATE PRONOUNCED DEAD
MONTH DAY YEAR
2 7 19 82 | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
NEW YORK | | 7b. CITIZEN OF WHAT COUNTRY?
USA | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
Baltimore City MD | | |
| 10. CITY OR TOWN OF DEATH
Baltimore | | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
Sinai Hospital | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)
PHYSICIAN | | 12b. KIND OF BUSINESS OR INDUSTRY
MEDICINE |
| USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)
13a. STATE
MARYLAND | | | 13b. COUNTY | | 13c. CITY OR TOWN
BALTIMORE | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
THEODORE N. HELLER | | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
ADELE EBEL | | | 13e. STREET ADDRESS
3201 1/2 FALLSTAFF RD. 21215 | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO, OR UNKNOWN)
YES | | 16b. SOCIAL SECURITY NO.
212-46-6747 | | 17. INFORMANT
MRS. ELLEN HELLER
3201 1/2 FALLSTAFF RD. BALTO., MD 21215 | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Arteriosclerotic cardiovascular disease
4292 } DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. (b) DUE TO, OR AS A CONSEQUENCE OF (c) | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 | | | | | | | | |
| 19a. DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | | | | 20. AUTOPSY?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. EXTERNAL CAUSE WAS
UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH | | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) | | | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/> | | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) | | 21f. LOCATION
CITY OR TOWN COUNTY STATE | | | |
| 22a. I certify that I took charge of the remains described above, held on death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion | | | | | | | | |
| ACTUAL SIGNATURE
Thomas D. Smith, M.D. | | | TITLE (SPECIFY)
Deputy Chief MEDICAL EXAMINER | | | DATE SIGNED
2/8/82 | | |
| EXAMINER'S NAME
(TYPE OR PRINT)
Thomas D. Smith, M.D. | | | ADDRESS
111 Penn Street, Balto., MD 21201 | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)
BURIAL | | | 23b. DATE
FEB. 9, 1982 | | 23c. NAME OF CEMETERY OR CREMATORY
CHIZUK AMUNO | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
BALTIMORE MARYLAND | |
| 24. FUNERAL DIRECTOR
NAME
SOL LEVINSON & BROS., INC.
6010 REISTERSTOWN RD. BALTO., MD 21215 | | | | | 25a. DATE REC'D. BY REGISTRAR
FEB 11 1982 | | | |
| | | | | | 25b. REGISTRAR'S SIGNATURE
James J. Nathan | | | |



STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 2 0 3 8 2 2

1 - FOR
STATE
REGISTRAR

REG. NO.

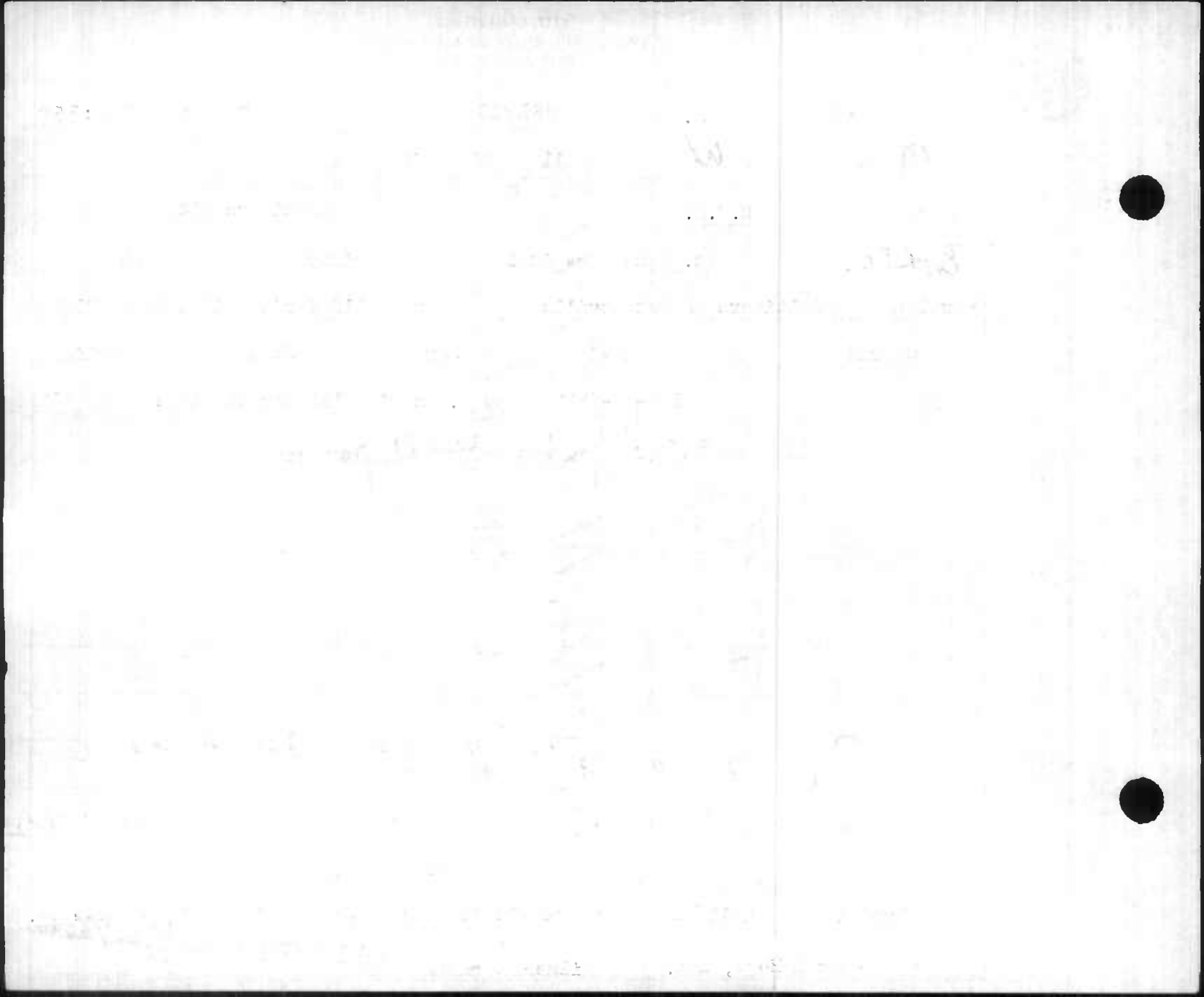
| | | | | | | | |
|---|--|---|---|---|---|--|--|
| 1. DECEASED NAME
(TYPE OR PRINT)
JAMES A. HELVIG | | | 2a. DATE OF DEATH
MONTH DAY YEAR
2 8 82 | | | 2b. HOUR
4:35 P.M. | |
| 3. SEX
Male | 4. RACE
White | 5. DATE OF BIRTH
MONTH DAY YEAR
11 26 01 | 6. AGE (IN YEARS LAST BIRTHDAY)
80 | | IF UNDER 1 YEAR
MONTHS DAYS HOURS MIN. | | |
| 7a. BIRTHPLACE
(COUNTRY)
Pennsylvania | 7b. CITIZEN OF WHAT COUNTRY?
U.S.A. | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 9. BALTIMORE CITY OR COUNTY OF DEATH
Baltimore City MD | | | | |
| 10. CITY OR TOWN OF DEATH
Baltimore | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
St. Agnes Hospital | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
Miner | | 12b. KIND OF BUSINESS OR INDUSTRY
Coal | | |
| 13a. STATE
Maryland | | 13b. CITY OR TOWN
Catonsville | 13d. INSIDE CITY LIMITS?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 13e. STREET ADDRESS
115 Garden Ridge Road 21228 | | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
Conrad Helvig | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
Mary Jane Rawlings | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
NO | | 16b. SOCIAL SECURITY NO.
195-09-6322 | | 17. INFORMANT
ADDRESS
Ray C. Helvig 133 Garden Ridge Road 21228 | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY
IMMEDIATE CAUSE (a) Cor pulmonale (3) pneumonia
4169
DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b) _____
DUE TO, OR AS A CONSEQUENCE OF
(c) _____ | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a) _____ | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | |
| 21d. INJURY OCCURRED
WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from Feb. 7, 1982 to Feb. 8, 1982 , that (I) (we) last saw the deceased alive on Feb. 7, 1982 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death. | | | | | | | |
| 22b. SIGNATURE
[Signature] | | | | DEGREE
ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | 22c. DATE SIGNED
Feb. 8, 1982 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
[Name] | | | | 22e. ADDRESS
900 Caton Avenue | | | |
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)
Burial | | 23b. DATE
2/11/82 | | 23c. NAME OF CEMETERY OR CREMATORY
Ceasedale Cemetery | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
Jackson Township Luzerne Pa. | |
| 24. FUNERAL DIRECTOR
Hubbard Funeral Home, Inc. 4107 Wilkens Avenue | | | | 25a. DATE REC'D. BY REGISTRAR
FEB 11 1982 | | 25b. REGISTRAR
[Signature] | |

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified before.



TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

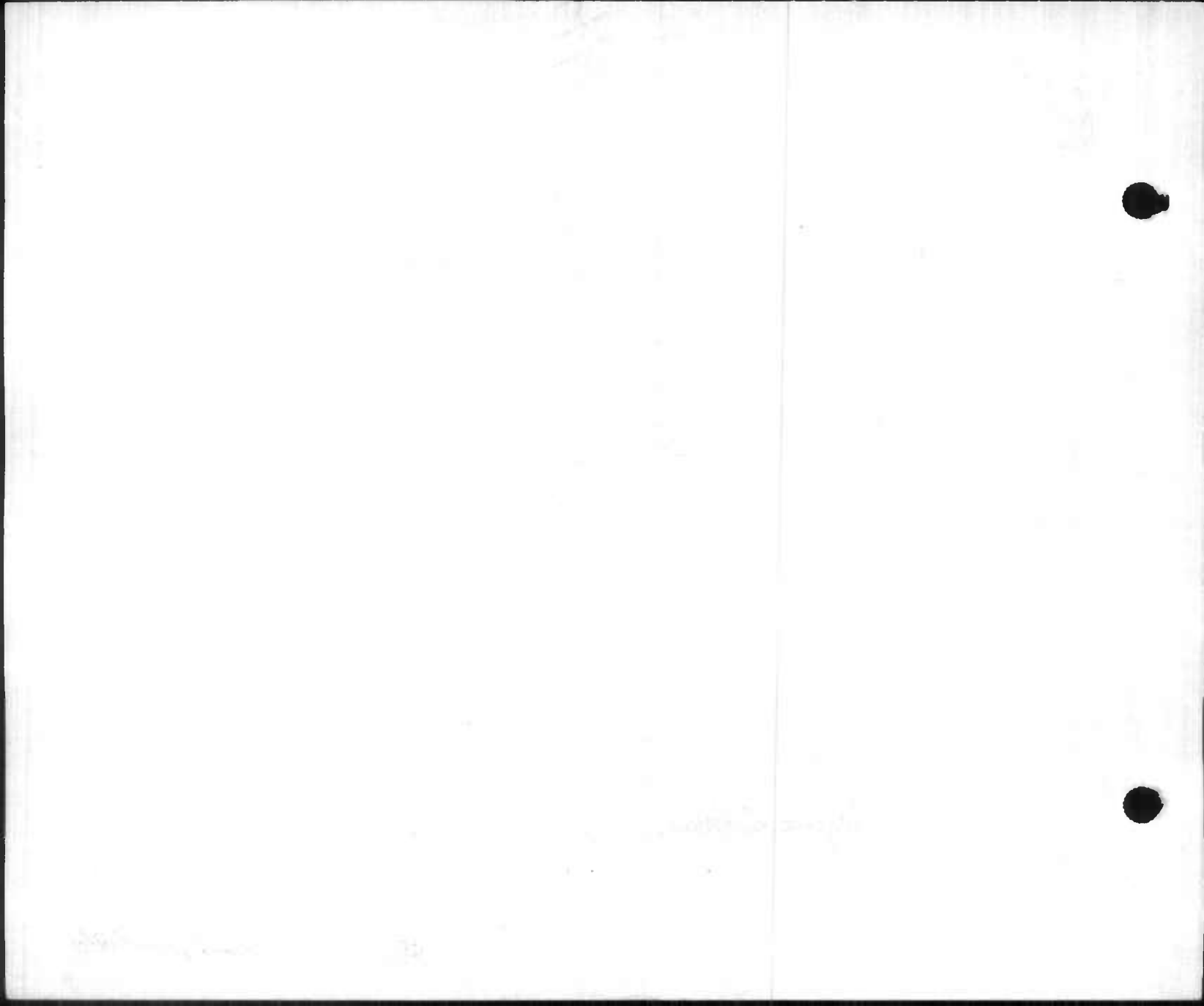
REG. NO.

1- FOR
STATE
REGISTRAR

| | | | | | | | | | | |
|--|---------|--|--------|---|-------------------------|---|---|---|------------|--|
| 1. DECEASED NAME
(TYPE OR PRINT) | | FIRST | MIDDLE | LAST | 2a. DATE KNOWN OF DEATH | | <input checked="" type="checkbox"/> MONTH | DAY | YEAR | 2b. HOUR |
| Noah Henson | | | | | 2a. DATE KNOWN OF DEATH | | <input checked="" type="checkbox"/> 2 | 14 | 19 82 | M |
| 3. SEX | 4. RACE | 5. DATE OF BIRTH | | 6. AGE (IN YEARS) | IF UNDER 1 YR. | IF UNDER 24 HRS. | 7c. DATE PRONOUNCED DEAD | | MONTH | DAY |
| Male | Black | 7 4 02 | | 79 YRS. | MONTHS | DAYS | 2 14 19 82 | | 3:38 P. M. | |
| 7b. BIRTHPLACE (STATE OR FOREIGN COUNTRY) | | 7b. CITIZEN OF WHAT COUNTRY? | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH | | | | |
| MD | | USA | | WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | Baltimore City, MD | | | | |
| 10. CITY OR TOWN OF DEATH | | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | | 12b. KIND OF BUSINESS OR INDUSTRY | | |
| Baltimore | | University Hospital | | | | | | | | |
| USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) | | | | | | | | | | |
| 13a. STATE | | 13b. COUNTY | | 13c. CITY OR TOWN | | 13d. INSIDE CITY LIMITS? | | 13e. STREET ADDRESS | | |
| MD | | | | Baltimore | | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 2414 Annor Court | | |
| 14. FATHER'S NAME | | | | 15. MOTHER'S MAIDEN NAME | | | | | | |
| FIRST MIDDLE LAST Samuel Henson | | | | FIRST MIDDLE LAST Grace Foster | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO, OR UNKNOWN) | | | | 16b. SOCIAL SECURITY NO. | | 17. INFORMANT ADDRESS | | | | |
| No | | | | 218-18-1860 | | Aldora Henson 2414 Annor Ct. | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Arteriosclerotic Cardiovascular Disease
4292 } DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.
(b) }
(c) }
DUE TO, OR AS A CONSEQUENCE OF | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a). | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | | | | 20. AUTOPSY? | | |
| | | | | | | | | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH | | | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) | | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/> | | | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | | |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> . | | | | | | | | | | |
| ACTUAL SIGNATURE <i>Virginia L. Dolan</i> | | | | TITLE (SPECIFY) Assistant | | | | DATE SIGNED 2-15-82 | | |
| EXAMINER'S NAME (TYPE OR PRINT) Virginia L. Dolan, M.D. | | | | ADDRESS 111 Penn Street | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) | | 23b. DATE | | 23c. NAME OF CEMETERY OR CREMATORY | | 23d. LOCATION | | 23e. COUNTY | | |
| Burial | | 2/19/82 | | Mt. Auburn Cem. | | Baltimore | | MD | | |
| 24. FUNERAL DIRECTOR NAME | | | | ADDRESS | | | | 25a. DATE REC'D. BY REGISTRAR | | |
| Wm. C. March F/H | | | | 1101 E. North Ave. | | | | FEB 16 1982 | | |
| | | | | | | | | 25b. REGISTRAR'S SIGNATURE <i>Thomas J. Smith</i> | | |

BP

DHMH - 17
(VR A15 ME (5))
15M 2/80



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 3 and 4 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

Item 7a g566 4/21/82 gj

1 - STATE REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 2 0 3 8 2 4

REG. NO.

| | | | | | | |
|--|--|---|---|--|---|--|
| 1. DECEASED NAME
(TYPE OR PRINT)
FIRST MIDDLE LAST
Lucille Herbert | | | 2a. DATE OF DEATH
MONTH DAY YEAR
2/21/82 | | 2b. HOUR
5 ¹⁵ P.M. | |
| 3. SEX
female | | 4. RACE
black | | 5. DATE OF BIRTH
MONTH DAY YEAR
12 23 98 | | |
| 6. AGE (IN YEARS LAST BIRTHDAY)
83 YRS. | | 7. UNDER 1 YEAR
MONTHS DAYS | | 8. UNDER 24 HRS.
HOURS MIN. | | |
| 9a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
U.S.A.C. | | 9b. CITIZEN OF WHAT COUNTRY?
U.S.A. | | 9c. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | |
| 10. CITY OR TOWN OF DEATH
Baltimore City | | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
Baltimore City Hospitals | | | |
| 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
housewife | | | 12b. KIND OF BUSINESS OR INDUSTRY | | | |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) | | | | | | |
| 13a. STATE
Maryland | | 13b. COUNTY | | 13c. CITY OR TOWN
Baltimore City | | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
William Browne | | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
Josephine Lawrence | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
NO | | 16b. SOCIAL SECURITY NO.
(IF YES, GIVE WAR OR DATES)
218-01-7972 | | 17. INFORMANT
ADDRESS
Samuel HERBERT 2011 E. Chase | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>Cardiogenic Shock</u>
4280
DUE TO, OR AS A CONSEQUENCE OF
(b) <u>Sepsis Shock</u>
DUE TO, OR AS A CONSEQUENCE OF
(c) <u>25.5% Total body surface area burns</u> | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
12 hours
16 hours
one month | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a):
<u>Congestive heart failure, hypertension</u> | | | | | | |
| 19a. DATE OF OPERATION
2/19/82 | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED
Infected third degree burns | | 20a. AUTOPSY?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | |
| 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | |
| 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 1 21 1982 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)
Robie caught fire standing near space heater | | | | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)
home | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE
2011 E. Chase St., Baltimore Md 21213 | | |
| 22a. I certify that (a) (this hospital) attended the deceased from <u>2/1</u> , 19 <u>82</u> , to <u>2/21</u> , 19 <u>82</u> , that (b) (we) last saw the deceased alive on <u>2/21</u> , 19 <u>82</u> , and that in (c) (our) opinion death occurred on the date and hour and from the causes stated above. (d) (we) (did) (did not) view the body after death. | | | | | | |
| 22b. SIGNATURE
David Sowa MD | | | | 22c. DATE SIGNED
2/21/82 | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
DAVID SOWA MD | | | | 22e. ADDRESS
Baltimore City Hospitals | | |
| 23a. BURIAL, CREMATION, REMOVAL | | 23b. DATE
2/26/82 | | 23c. NAME OF CEMETERY OR CREMATORY
Md. Natl. Mem. Park | | |
| 23d. LOCATION
CITY OR TOWN
Laurel | | 23e. DATE REC'D. BY REGISTRAR
FEB 22 1982 | | | | |
| 24. FUNERAL DIRECTOR
NAME
Calvin B. Scruggs | | 25. REGISTRAR
NAME
Frances Jan Nathan | | | | |

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 2 0 3 8 2 5

1. FOR
STATE
REGISTRAR

REG. NO.

| | | | | | | | | | |
|---|--|--|--|---|---|---|---|--|--|
| 1. DECEASED NAME
(TYPE OR PRINT)
EDWARD DANIEL HERCHE | | | 2a. DATE OF DEATH
MONTH DAY YEAR
FEBRUARY 25, 1982 | | | 2b. HOUR
4:30A | | | |
| 3. SEX
Male | | 4. RACE
White | | 5. DATE OF BIRTH
MONTH DAY YEAR
10/8/1914 | | 6. AGE (IN YEARS LAST BIRTHDAY)
67 YRS. | | IF UNDER 1 YEAR
MONTHS DAYS HOURS MIN. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
Md. | | 7b. CITIZEN OF WHAT COUNTRY?
U.S.A. | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
BALTIMORE CITY MD. | | | |
| 10. CITY OR TOWN OF DEATH
Baltimore | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
JOHNS HOPKINS HOSPITAL | | | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
Machine Operator Elec. | | | |
| 13a. STATE
Md. | | 13b. COUNTY
- | | 13c. CITY OR TOWN
Balto. | | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS
3110 E. Monument St. | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
John F. Herche | | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
unknown | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
yes | | 16b. SOCIAL SECURITY NO.
(IF YES, GIVE WAR OR DATES)
1942-1943 | | 17. INFORMANT
Dolores Herche (wife) | | ADDRESS
same address | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART 1. DEATH WAS CAUSED BY:
3989 IMMEDIATE CAUSE (a) cardiopulmonary disease
DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b) _____
DUE TO, OR AS A CONSEQUENCE OF
(c) _____ | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)
pneumatic heart disease | | | | | | | | | |
| 19a. DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/> | | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from Feb 22, 1982 , to Feb 25, 1982 , that (I) (we) last saw the deceased alive on Feb 25, 1982 ; and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) did not view the body after death. | | | | | | | | | |
| 22b. SIGNATURE
Francine Welty M.D. DEGREE
ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> | | | | | | 22c. DATE SIGNED
2/25/82 | | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
F. Welty | | | | | | 22e. ADDRESS
Johns Hopkins | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)
Burial | | | 23b. DATE
3/1/82 | | 23c. NAME OF CEMETERY OR CREMATORY
Bohemian Nat'l | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
Baltimore, Md. | | |
| 24. FUNERAL DIRECTOR
Schimmunek Funeral Home, Inc.
3331 Brehms Lane, Balto. Md. 21213 | | | | | | 25a. DATE REC'D. BY REGISTRAR
MAR 1 1982 | | | |
| | | | | | | 25b. REGISTRAR'S SIGNATURE
Thomas J. Nathan | | | |

CHARTERED

5

CHARTER

CHARTER

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the local health department with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP 10

DHMH - 16 50M 1/81
(VRA 15, 4)

| STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH | | | | | | | | | | 8 2 0 3 8 2 6 | | | |
|--|--|--|--|---|--|--|--|---|--|--|--|--|--|
| 1 - FOR STATE REGISTRAR | | | | | | | | | | REG. NO. | | | |
| 1. DECEASED NAME (TYPE OR PRINT)
FIRST MIDDLE LAST
Jennie Bedrick Herzog | | | | | | 2a. DATE OF DEATH MONTH DAY YEAR
February 24, 1982 | | | | 2b. HOUR
11:25 PM | | | |
| 3. SEX
FEMALE | | 4. RACE
WHITE | | 5. DATE OF BIRTH MONTH DAY YEAR
MARCH 15, 1892 | | 6. AGE (IN YEARS (LAST BIRTHDAY))
89 | | IF UNDER 1 YEAR MONTHS DAYS
IF UNDER 24 HRS. HOURS MIN. | | | | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
POLAND | | 7b. CITIZEN OF WHAT COUNTRY?
U.S.A. | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
Baltimore City MD. | | | | | | | |
| 10. CITY OR TOWN OF DEATH
Baltimore | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
Maryland General Hospital | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)
RETIRED | | 12b. KIND OF BUSINESS OR INDUSTRY
SECRETARY | | | | | |
| 13a. STATE
MARYLAND | | 13b. COUNTY
HOWARD | | 13c. CITY OR TOWN
COLUMBIA | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS
9689 BASKET RING COLUMBIA 21045 | | | | | |
| 14. FATHER'S NAME FIRST MIDDLE LAST
SAMUEL BEDRICK | | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST
MIRIAM (UNKNOWN) | | | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)
NO | | 16b. SOCIAL SECURITY NO.
108-26-2096 | | 17. INFORMANT ADDRESS
MARK RYDER 9689 BASKET RING COLUMBIA MD. | | | | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART 1. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Sepsis
DUE TO, OR AS A CONSEQUENCE OF (b) Pneumonia
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO, OR AS A CONSEQUENCE OF (c) | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) | | | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | | | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | | | | | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | | | | | | | |
| 22a. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from February 21, 1982 , to February 24, 1982 , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on February 24, 1982 , and that in <input checked="" type="checkbox"/> (my) (our) opinion death occurred on the date and hour and from the causes stated above. <input checked="" type="checkbox"/> (we) (did) <input checked="" type="checkbox"/> (not) view the body after death. | | | | | | | | | | | | | |
| 22b. SIGNATURE
Mohammad Aslam M.D. | | | | DEGREE
M.D. | | | | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> | | 22c. DATE SIGNED
2/24/82 | | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
Mohammad Aslam, M.D. | | | | 22e. ADDRESS
C/O Maryland General Hospital | | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)
CREMATION | | 23b. DATE
FEB. 26, 1982 | | 23c. NAME OF CEMETERY OR CREMATORY
WESTVIEW MEMORIAL | | 23d. LOCATION CITY OR TOWN COUNTY STATE
CATONSVILLE MARYLAND | | | | | | | |
| 24. FUNERAL DIRECTOR
LEROY & RUSSELL WITZKE FUNERAL HOME OF COLUMBIA | | | | | | 25a. DATE REC'D. BY REGISTRAR
MAR 2 1982 | | 25b. REGISTRAR'S SIGNATURE
<i>Theresa J. [Signature]</i> | | | | | |
| 5555 TWIN KNOLLS ROAD COLUMBIA MD. 20045 | | | | | | | | | | | | | |

(100)

Document

APR 3 1967

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 2 0 3 8 2 7

FOR
1- STATE
REGISTRAR

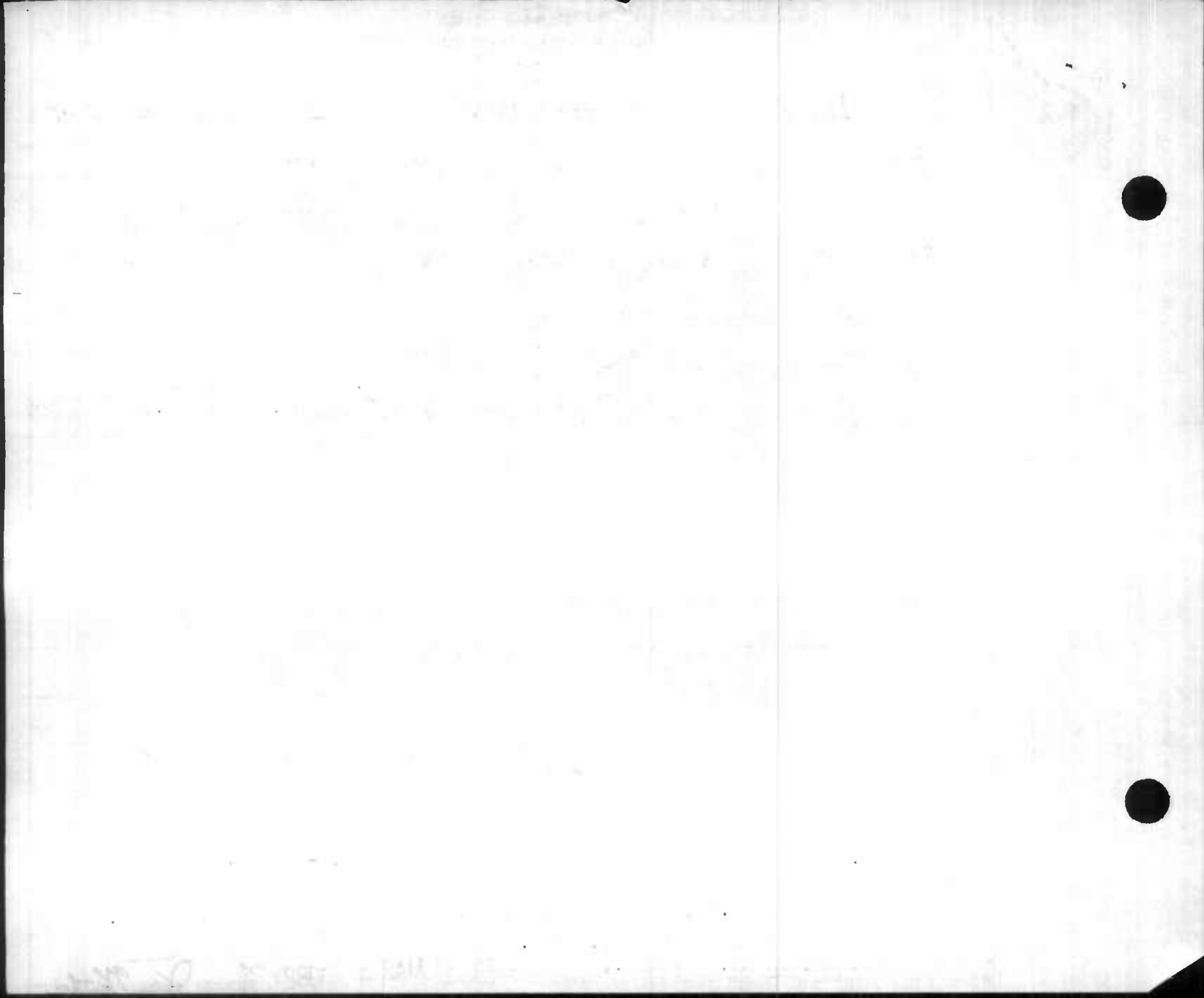
REG. NO.

| | | | | | |
|---|---|---|---|--|---|
| 1. DECEASED NAME
(TYPE OR PRINT)
IRMA HEYMANN | | | 2a. DATE OF DEATH
MONTH DAY YEAR
2 24 '82 | | 2b. HOUR
1:45P |
| 3. SEX
Female | 4. RACE
white | 5. DATE OF BIRTH
MONTH DAY YEAR
10 27 1897 | | 6. AGE (IN YEARS LAST BIRTHDAY)
84 YRS | IF UNDER 1 YEAR
MONTHS DAYS HOURS MIN. |
| 7a. BIRTHPLACE
(STATE OR FOREIGN COUNTRY)
GERMANY | 7b. CITIZEN OF WHAT COUNTRY?
USA | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
BALTIMORE CITY MD | |
| 10. CITY OR TOWN OF DEATH
BALTIMORE | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
SINAI HOSPITAL OF BALT. | | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
HOUSEWIFE | 12b. KIND OF BUSINESS OR INDUSTRY
AT HOME |
| 13a. STATE
MD | 13b. COUNTY | 13c. CITY OR TOWN
BALTO | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | 13e. STREET ADDRESS
7226 Park Heights Ave Apt C | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
WILLIE WOLF MATHIAS | | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
JULIA WITTGENSTEIN | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO, OR UNKNOWN)
NO | | 16b. SOCIAL SECURITY NO.
296-325567 | | 17. INFORMANT
ADDRESS
MRS. GERTIE OPPENHEIMER
3219 TIMBERFIELD LA. BALTO., MD 21208 | |
| 18. CAUSE OF DEATH: Enter only one cause per line for (a), (b), and (c).
PART 1. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) pulmonary edema
4148
DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last:
(b) chronic CHF
DUE TO, OR AS A CONSEQUENCE OF
(c) ascrd, severe & pericardial | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)
digitalis toxicity | | | | | |
| 19a. DATE OF OPERATION
2/15 | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | |
| 22a. I certify that (I) (this hospital) attended the deceased from 2/15 , 19 82 , to 2/24 , 19 82 , that (I) (we) last saw the deceased alive on 2/24 , 19 82 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | |
| 22b. SIGNATURE
DR. LIM | | | DEGREE
M.D. | | 22c. DATE SIGNED
2-24-82 |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
DR. LIM | | | 22e. ADDRESS
SINAI HOSP. - BALTO., MD | | |
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)
BURIAL | | 23b. DATE
FEB. 26, 1982 | 23c. NAME OF CEMETERY OR CREMATORY
CHEVRA AHAVAS CHESED | | 23d. LOCATION
STREET CITY OR TOWN COUNTY STATE
RANDALLSTOWN BALTO. MD |
| 24. FUNERAL DIRECTOR
NAME
SOL LEVINSON & BROS., INC.
6010 REISTERSTOWN RD. BALTO., MD 21215 | | | 25a. DATE REC'D. BY REGISTRAR
MAR 4 1982 | | |
| | | | 25b. REGISTRAR'S SIGNATURE
Charles J. Nathan | | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Part 1, however, may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

| STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH | | | | | 82 03828 | | | | |
|--|--|---|--|---|--|--|--|---|--|
| 1 - FOR STATE REGISTRAR | | | | | REG. NO. | | | | |
| 1. DECEASED NAME (TYPE OR PRINT)
FIRST MIDDLE LAST
Barbara Ann Hicks | | | | | 2a. DATE OF DEATH MONTH DAY YEAR
2-24-82 | | | 2b. HOUR
4:17P _M | |
| 3. SEX
Female | | 4. RACE
White | | 5. DATE OF BIRTH MONTH DAY YEAR
10 11 1934 | | 6. AGE (IN YEARS LAST BIRTHDAY)
47 YRS. | | IF UNDER 1 YEAR
MONTHS DAYS
IF UNDER 24 HRS
HOURS MIN. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
Maryland | | 7b. CITIZEN OF WHAT COUNTRY?
USA | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
Baltimore City MD. | | | |
| 10. CITY OR TOWN OF DEATH
Baltimore | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
John Hopkins Hospital | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)
Housewife | | 12b. KIND OF BUSINESS OR INDUSTRY
Homemaking | | |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)
13a. STATE 13b. COUNTY 13c. CITY OR TOWN
Maryland Harford Kingsville | | | | | 13d. INSIDE CITY LIMITS?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 13e. STREET ADDRESS
801 Karen Drive 21087 | | |
| 14. FATHER'S NAME FIRST MIDDLE LAST
Edward A. Frey | | | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST
Katherine F. Fowler | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)
No | | 16b. SOCIAL SECURITY NO.
(IF YES, GIVE WAR OR DATES)
214-30-6949 | | 17. INFORMANT ADDRESS
Harold A. Hicks 801 Karen Drive | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART 1. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>CARDIORESPIRATORY ARREST</u>
0709
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b) <u>Myocardial infarction</u>
(c) <u>ACUTE FULMINANT HEPATITIS</u> | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
45min
45min
7days | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)
<u>Chronic renal failure, SP renal transplant X 2</u> | | | | | | | | | |
| 19a. DATE OF OPERATION
2/9/82 | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED
Renal failure | | | 20a. AUTOPT? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF OTHER, NOTIFY MEDICAL EXAMINER)
WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | | | |
| 21d. INJURY OCCURRED
21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)
21f. LOCATION (STREET) CITY OR TOWN COUNTY STATE | | | | | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>2/9</u> 19 <u>82</u> to <u>2/24</u> 19 <u>82</u> that (I/we) last saw the deceased alive on <u>2/24</u> 19 <u>82</u> , and that in (my/our) opinion death occurred on the date and hour and from the causes stated above. (I/we) (did not) view the body after death. | | | | | | | | | |
| 22b. SIGNATURE
[Signature]
22d. PHYSICIAN'S NAME (TYPE OR PRINT)
R C KURCZYK | | | | | DEGREE
ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> | | | 22c. DATE SIGNED
2/24 | |
| 22e. ADDRESS
10 HAS HOPKINS HOSP | | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)
Burial | | 23b. DATE
2/27/82 | | 23c. NAME OF CEMETERY OR CREMATORY
Parkwood Cemetery | | 23d. LOCATION CITY OR TOWN COUNTY STATE
Parkville Baltimore Md. | | | |
| 24. FUNERAL DIRECTOR
[Signature]
24b. ADDRESS
7401 Belvoir Rd | | | | | 25a. DATE REC'D. BY REGISTRAR
MAR 1 1982 | | 25b. REGISTRAR'S SIGNATURE
[Signature] | | |

0000 BP

10012

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

| STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH | | | | 8 2 0 3 8 2 9 | | | |
|---|-----------------|---|--|--|--|---|--|
| 1 - FOR STATE REGISTRAR | | | | REG. NO. | | | |
| 1 DECEASED NAME (TYPE OR PRINT)
PAUL W. HICKSON | | | | 2a DATE OF DEATH
FEB 5 82 | | 2b HOUR
1:20P M | |
| 3 SEX
MALE | 4 RACE
BLACK | 5 DATE OF BIRTH
MONTH 6 DAY 2 YEAR 21 | | 6 AGE (IN YEARS LAST BIRTHDAY)
60 YRS. | | IF UNDER 1 YEAR
MONTHS DAYS | |
| 7a BIRTHPLACE (STATE OR FOREIGN COUNTRY)
SOUTH CAROLINA | | 7b CITIZEN OF WHAT COUNTRY?
U.S.A. | | 8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9 BALTIMORE CITY OR COUNTY OF DEATH
BALTIMORE CITY MD. | |
| 10 CITY OR TOWN OF DEATH
BALTIMORE | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
VAMC, LOCH RAVEN BALTO. MD | | 12a USUAL OCCUPATION (TYPE WORK FOR MOST OF WORKING LIFE)
GUARD | | 12b KIND OF BUSINESS OR INDUSTRY
FACTORY | |
| 13a USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)
BALTIMORE | | 13b COUNTY
BALTIMORE | | 13c INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13d STREET ADDRESS
2541 W. NORTH AVE. 21216 | |
| 14 FATHER'S NAME
ALSBAM | | 15 MOTHER'S MAIDEN NAME
HATTIE McCRAY | | 16a WAS DECEASED EVER IN U.S. ARMED FORCES?
YES (YES, NO OR UNKNOWN) | | 16b SOCIAL SECURITY NO.
231 01 8637 | |
| 17a WAS DECEASED EVER IN U.S. ARMED FORCES?
YES (YES, NO OR UNKNOWN) | | 17b SOCIAL SECURITY NO.
231 01 8637 | | 17c DATE OF DEATH
FEB 5 82 | | 17d DATE OF DEATH
FEB 5 82 | |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART 1. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>Respiratory arrest</u>
DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b) <u>Cocaine</u>
DUE TO, OR AS A CONSEQUENCE OF
(c) _____ | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: _____ | | | | | | | |
| 19a DATE OF OPERATION | | 19b CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a AUTOPSY?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | 21d LOCATION
CITY OR TOWN COUNTY STATE | |
| 21e INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK AT WORK | | 21f PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21g LOCATION
CITY OR TOWN COUNTY STATE | | 21h LOCATION
CITY OR TOWN COUNTY STATE | |
| 22a I certify that (I) (this hospital) attended the deceased from <u>DECEMBER 30, 1981</u> to <u>FEBRUARY 5, 1982</u> , that <input checked="" type="checkbox"/> (we) lost saw the deceased above, and that in my (our) opinion death occurred on the date and hour and from the causes stated above, <input checked="" type="checkbox"/> (we) (did) (and) (not) view the body after death. | | | | | | | |
| 22b SIGNATURE
R. V. Davis M.D. | | DEGREE | | ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | 22c DATE SIGNED | |
| 22d PHYSICIAN'S NAME (TYPE OR PRINT)
R. V. DAVIS MD | | 22e ADDRESS
3900 LOCH RAVEN BLVD BALTIMORE, MD 21218 | | | | | |
| 23a BURIAL, CREMATION, REMOVAL
BURIAL | | 23b DATE
2-11-82 | | 23c NAME OF CEMETERY OR CREMATORY
CROWNSVILLE U.A.C.M. | | 23d LOCATION
CITY OR TOWN COUNTY STATE
CROWNSVILLE B.A. Co MD | |
| 24 FUNERAL DIRECTOR
NAME
JOSEPH L. RUSS | | 24b ADDRESS
2222 W. NORTH AVE | | 24c DATE REC'D. BY REGISTRAR
FEB 9 1982 | | 24d REGISTRAR
James Santhos | |

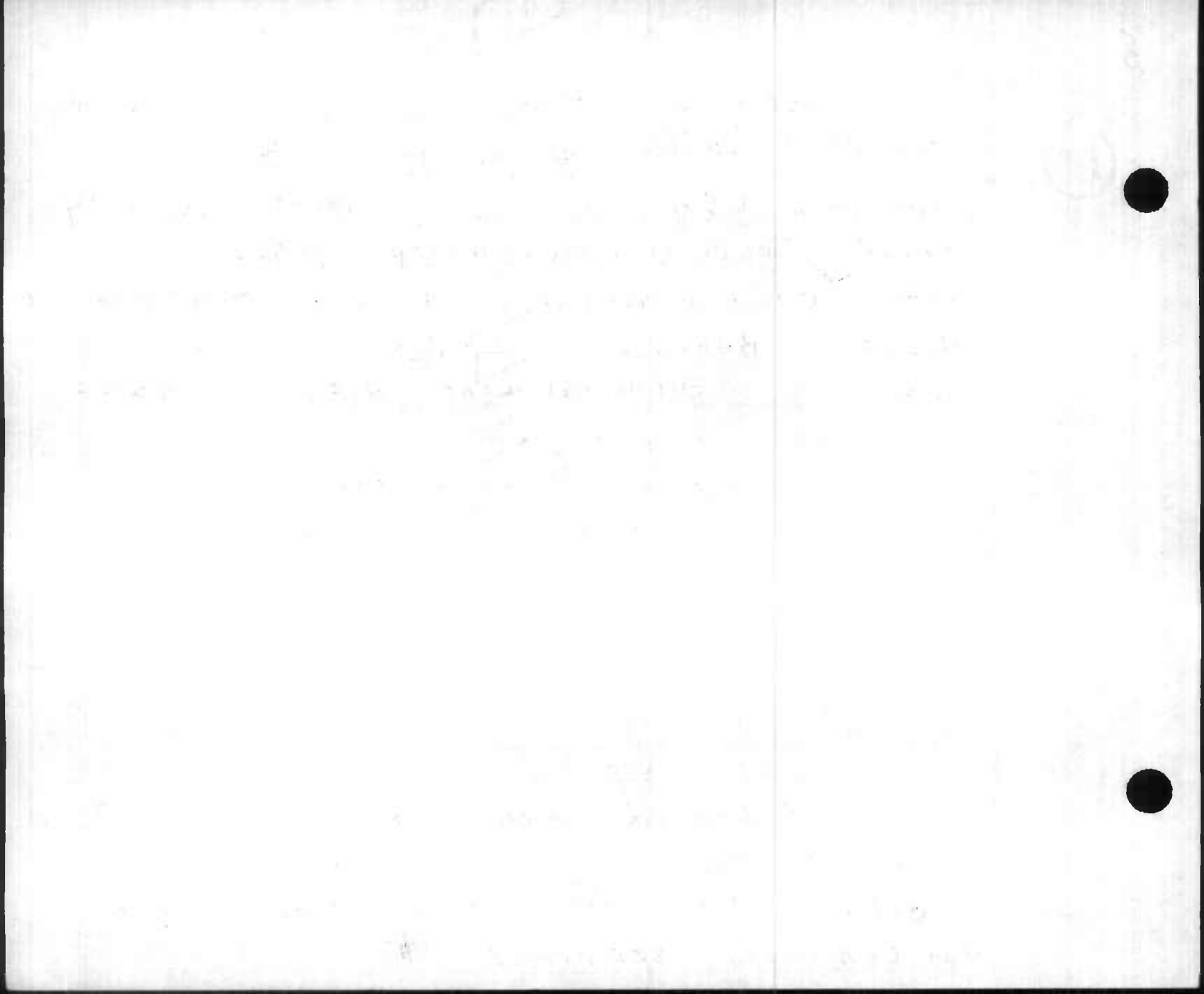
Handwritten notes and a small diagram or sketch in the upper middle section of the page.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death and retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers, Pages 1 and 2 should be filed within 10 days after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

| STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH | | | | | | | | | | 8 2 0 3 8 3 0 | | | |
|--|--|--|--|---|--|---|--|--|--|--|--|--|--|
| FOR
1 - STATE
REGISTRAR | | REG. NO. | | | | | | | | | | | |
| 1. DECEASED NAME
(TYPE OR PRINT)
FIRST MIDDLE LAST
Beverly J. High | | | | | | 2a. DATE OF DEATH
MONTH DAY YEAR
2 27 82 | | | | 2b. HOUR
1:40 PM | | | |
| 3. SEX
female | | 4. RACE
white | | 5. DATE OF BIRTH
MONTH DAY YEAR
7 29 31 | | 6. AGE (IN YEARS LAST BIRTHDAY)
50 YRS | | IF UNDER 1 YEAR
MONTHS DAYS | | IF UNDER 24 HRS
HOURS MIN | | | |
| 7a. BIRTHPLACE
(STATE OR FOREIGN COUNTRY)
CALIFORNIA | | 7b. CITIZEN OF WHAT COUNTRY?
USA | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
Baltimore City MD | | | | | | | |
| 10. CITY OR TOWN OF DEATH
BALTO. | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
The Good Samaritan Hosp | | | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
H SWE | | 12b. KIND OF BUSINESS OR INDUSTRY | | | | | |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)
13a. STATE
MD. | | 13b. COUNTY
BALTO | | 13c. CITY OR TOWN
MIDDLE RIVER | | 13d. INSIDE CITY LIMITS?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 13e. STREET ADDRESS
2141 LORALTHORN RD | | | | | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
STEVE BARONIE | | | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
LYDA SIMAS | | | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
NO | | 16b. SOCIAL SECURITY NO.
(IF YES, GIVE WAR OR DATES)
549-42-9161 | | 17. INFORMANT
ADDRESS
LEROY HIGH | | ABOVE | | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART 1. DEATH WAS CAUSED BY:
1629 IMMEDIATE CAUSE (a) Respiratory failure
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last:
(b) Probable Pulm. Embolus
(c) Cat Kill Cancer of Lungs | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) | | | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | | | | | |
| 21d. INJURY OCCURRED
WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) last saw the deceased alive on _____, 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | | | | | |
| 22b. SIGNATURE
Sandra L. Howard M.D. | | | | | | DEGREE
M.D. | | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | 22c. DATE SIGNED
2-27-82 | | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
Sandra L. Howard M.D. | | | | | | 22e. ADDRESS
3001 S. Hanover St. | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)
BURIAL | | 23b. DATE
3/2/82 | | 23c. NAME OF CEMETERY OR CREMATORY
HOLLY HILL | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
BALTO. MD. | | | | | | | |
| 24. FUNERAL DIRECTOR
NAME
J.G. CONNELLY | | | | | | ADDRESS
300 MACE | | 25. DATE REC'D BY REGISTRAR
MAR 3 1982 | | | | | |



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TO HOSPITAL OR ATTENDING PHYSICIAN. The law requires that this certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked of item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

DHMH-16 30M 2/80
(VRA 15, 4)1 - FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 2 0 3 8 3 1

REG. NO.

| | | | | | |
|--|--|---|---|--|--|
| 1. DECEASED NAME
(TYPE OR PRINT)
FRANCES HILL | | | 2a. DATE OF DEATH
MONTH DAY YEAR
FEBRUARY 06, 1982 | | 2b. HOUR
9:00p |
| 3. SEX
FEMALE | 4. RACE
NEGROID | 5. DATE OF BIRTH
MONTH DAY YEAR
June 29, 1915 | | 6. AGE (IN YEARS LAST BIRTHDAY)
66 YRS. | IF UNDER 1 YEAR
MONTHS DAYS
IF UNDER 24 HRS
HOURS MIN. |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
VIRGINIA | 7b. CITIZEN OF WHAT COUNTRY?
U.S.A. | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
BALTIMORE CITY MD. | |
| 10. CITY OR TOWN OF DEATH
BALTO. | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
JOHNS HOPKINS HOSPITAL | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
Disabled | | 12b. KIND OF BUSINESS OR INDUSTRY |
| 13a. STATE
MD. | | | 13b. COUNTY
Balto. | 13c. CITY OR TOWN
Balto. | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
Robert BOLLING | | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
HATTIE WINSTON | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
NO | | 16b. SOCIAL SECURITY NO.
(IF YES, GIVE WAR OR DATES)
217-18-7640 | | 17. INFORMANT
ADDRESS
ESTELLA BOLLING '602 Vincent St. | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Sepsis
4280 DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b) chronic renal failure
(c) congestive heart failure | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) | | | | | |
| 19a. DATE OF OPERATION
- | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED
- | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)
- | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK AT WORK | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)
- | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | |
| 22a. I certify that (I) (this hospital) attended the deceased from 1 Feb , 19 82 , to 6 Feb. , 19 82 , that (I) (we) last saw the deceased alive on Feb 6 , 19 82 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | |
| 22b. SIGNATURE
Hugh Rienhoff Jr. | | DEGREE
MD | | 22c. DATE SIGNED
6 FEB 82 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
HUGH Y. RIENHOFF JR. | | 22e. ADDRESS
J.H.H. | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)
Burial | | 23b. DATE
2-12-82 | | 23c. NAME OF CEMETERY OR CREMATORY
Cedar Hill Cem. | |
| 23d. LOCATION
CITY OR TOWN COUNTY STATE
Anne Arundel County MD | | 23e. DATE REC'D. BY REGISTRAR
FEB 8 1982 | | | |
| 24. FUNERAL DIRECTOR
NAME
CALVIN B. SCRUGGS | | ADDRESS
1412 E. Preston St. | | 25b. REGISTRAR'S SIGNATURE
Thom J. [Signature] | |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. It may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use on the burial-transit permit. Then please remove carbon copies. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

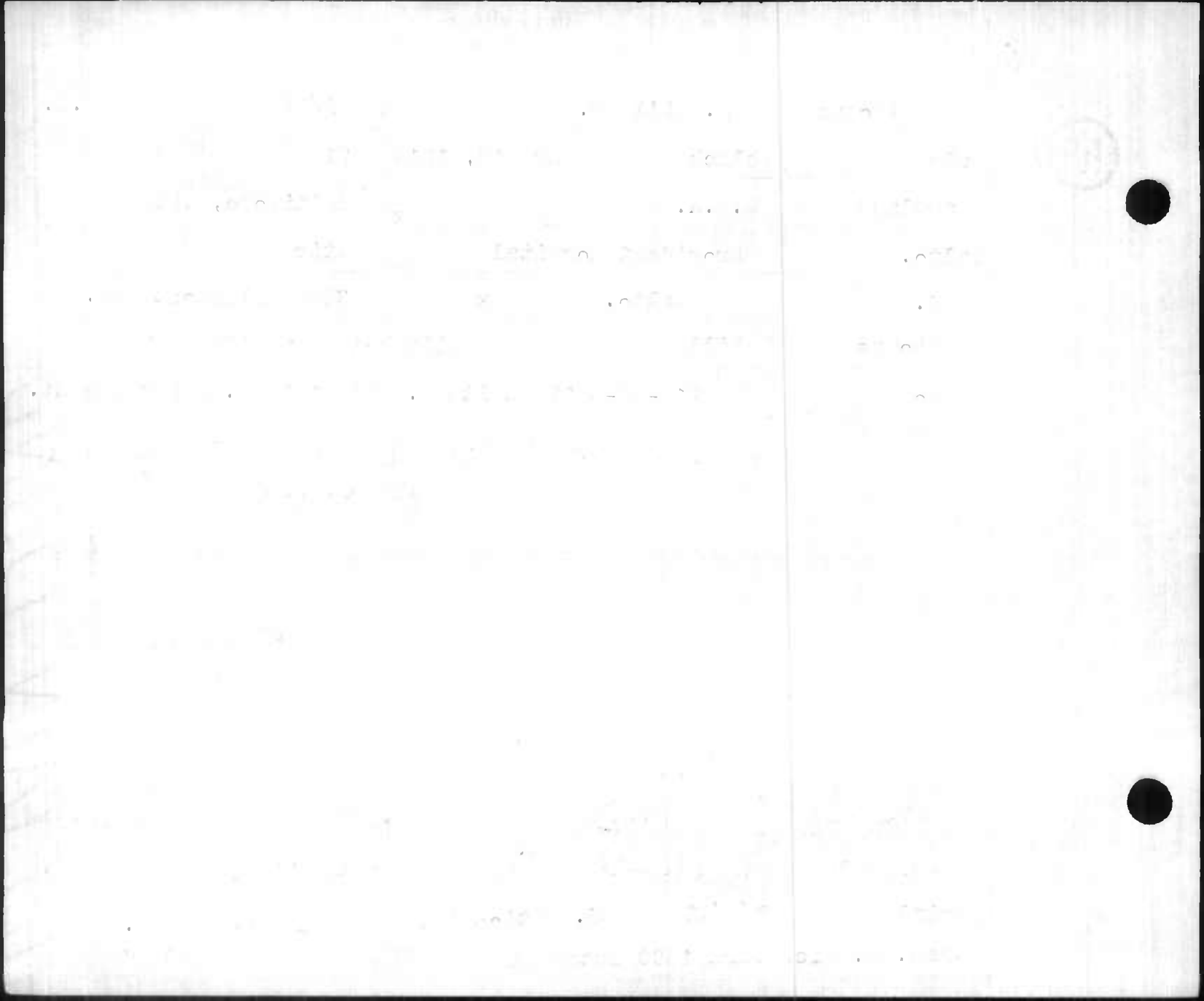
6
1- FOR STATE REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 2 0 3 8 3 2

REG. NO.

| | | | | | | | | | |
|--|--|--|--|---|--|--|---|--|--|
| 1. DECEASED NAME
(TYPE OR PRINT) Thomas B. Hill Sr. | | | 2a. DATE OF DEATH
2/3/82 | | | 2b. HOUR
2P.M. | | | |
| 3 SEX
male | | 4. RACE
black | | 5. DATE OF BIRTH
Aug 16, 1910 | | 6. AGE (IN YEARS LAST BIRTHDAY)
71 | | 7a. IF UNDER 1 YEAR
MONTHS DAYS HOURS MIN. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
Maryland | | 7b. CITIZEN OF WHAT COUNTRY?
U.S.A. | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
Baltimore, City | | | |
| 10. CITY OR TOWN OF DEATH
Balto. | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
Provident Hospital | | | | 12a. USUAL OCCUPATION
(TYPE WORK FOR MOST OF WORKING LIFE)
Retired | | 12b. KIND OF BUSINESS OR INDUSTRY | |
| 13a. STATE
Md. | | | 13b. COUNTY
Balto. | | 13c. CITY OR TOWN
Balto. | | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | |
| 14. FATHER'S NAME
Thomas Hill | | | 15. MOTHER'S MAIDEN NAME
Elizabeth Hill | | | 13e. STREET ADDRESS
3408 Piedmont Ave. | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
no | | | 16b. SOCIAL SECURITY NO.
218-05-0677 | | | 17. INFORMANT ADDRESS
Edith M. Hill 1910 W. Franklins St. | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), or (c).)
PART 1. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Arteriosclerotic Heart Disease
4140
DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b) _____
DUE TO, OR AS A CONSEQUENCE OF
(c) _____
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
years | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a): | | | | | | | | | |
| 19a. DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK AT WORK | | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 7/28 1977 to 10/28 1981 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death. | | | | | | | | | |
| 22b. SIGNATURE
[Signature] DEGREE MD | | | | | | 22c. DATE SIGNED
2/5/82 | | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
Old Frederick Rd | | | | | | 22e. ADDRESS
Baltimore 21229 | | | |
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)
Burial | | | 23b. DATE
2/8/82 | | 23c. NAME OF CEMETERY OR CREMATORY
Md. National Cem | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
Laurel MD. | | |
| 24. FUNERAL DIRECTOR
Chas. A. Rice FSPA 1300 Eutaw Pl | | | | | | 25a. DATE REC'D. BY REGISTRAR
FEB 5 1982 | | | |
| | | | | | | 25b. REGISTRAR'S SIGNATURE
[Signature] | | | |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified to certify.1 - FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | |
|---|---|---|---|--|---|
| 1. DECEASED NAME
(TYPE OR PRINT)
FIRST Anna MIDDLE Louise LAST Hiltz
<i>Anna Hiltz</i> | | | 2a. DATE OF DEATH
MONTH 2 DAY 1 YEAR 82 | | 2b. HOUR
4 ¹⁰ / _A M |
| 3. SEX
Female | 4. RACE
White | 5. DATE OF BIRTH
MONTH 7 DAY 10 YEAR 1888 | | 6. AGE (IN YEARS LAST BIRTHDAY)
93 YRS. | IF UNDER 1 YEAR
MONTHS 0 DAYS 0 |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
Balto., Maryland | 7b. CITIZEN OF WHAT COUNTRY?
USA | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
Baltimore C:Ty MD. | |
| 10. CITY OR TOWN OF DEATH
Baltimore | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
Lutheran Hospital of Maryland | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
Seamstress | 12b. KIND OF BUSINESS OR INDUSTRY
Retired | |
| 13a. STATE
Maryland | 13b. COUNTY
Baltimore | 13c. CITY OR TOWN
Catonsville | 13d. INSIDE CITY LIMITS?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | 13e. STREET ADDRESS
333 Harlem Lane - 21228 | |
| 14. FATHER'S NAME
FIRST ? MIDDLE ? LAST Hormes | 15. MOTHER'S MAIDEN NAME
FIRST ? MIDDLE ? LAST ? | | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN) No | | |
| 16b. SOCIAL SECURITY NO.
212-14-0914 | | 17. INFORMANT
ADDRESS -21229
Mr. & Mrs. Herman Graf, Jr. - 4610 Cedar Garden Rd | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART 1. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Cardiopulmonary arrest
2500
DUE TO, OR AS A CONSEQUENCE OF
(b) ASCVD
DUE TO, OR AS A CONSEQUENCE OF
(c) AODM | | | | | APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATH |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | 20b. IF YES, WERE FINDINGS USED
IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | |
| 22. I certify that (I) (this hospital) attended the deceased from 1/31 , 19 82 , to 2/1 , 19 82 , that (I) (we) last saw the deceased alive on 2/1 , 19 82 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did not) view the body after death. | | | | | |
| 22a. SIGNATURE
Henry Sander | | DEGREE | | 22c. DATE SIGNED
2/1/82 | |
| 22b. PHYSICIAN'S NAME (TYPE OR PRINT)
Henry Sander | | 22e. ADDRESS
Lutheran Hospital of Maryland | | | |
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)
Burial | 23b. DATE
Feb. 3, 1982 | 23c. NAME OF CEMETERY OR CREMATORY
Harkwood Cemetery | | 23d. LOCATION
CITY OR TOWN Baltimore, Md. COUNTY - STATE 21234 | |
| 24. FUNERAL DIRECTOR
NAME
Henry Sander & Sons, Inc., Balto., Md. 21213 | | 25a. DATE REC'D. BY REGISTRAR
FEB 5 1982 | | 25b. REGISTRAR'S SIGNATURE
<i>James J. [Signature]</i> | |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1. FOR
STATE
REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | |
|---|--|---|--|--|
| 1. DECEASED NAME
(TYPE OR PRINT)
HELEN E HIMES | | 2a. DATE OF DEATH
MONTH DAY YEAR
FEB 16 1982 | | 2b. HOUR
9:35 AM |
| 3. SEX
FEMALE | 4. RACE
WHITE | 5. DATE OF BIRTH
MONTH DAY YEAR
8 18 15 | 6. AGE (IN YEARS LAST BIRTHDAY)
66 YRS | IF UNDER 1 YEAR
MONTHS DAYS
IF UNDER 24 HRS
HOURS MIN. |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
Penna. | 7b. CITIZEN OF WHAT COUNTRY?
U.S.A | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 9. BALTIMORE CITY OR COUNTY OF DEATH
Baltimore City MD. | |
| 10. CITY OR TOWN OF DEATH
BALTO | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
NORTH CHARLES GENERAL HOSPITAL | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
waitress | 12b. KIND OF BUSINESS OR INDUSTRY
Restaurant | |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)
STATE COUNTY
Maryland Baltimore | 13b. CITY OR TOWN
Essex 21221 | 13c. INSIDE CITY LIMITS?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | 13e. STREET ADDRESS
4 C Fenway South | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
Jessie Smith | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
Elmira Grace Steel | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
No | 16b. SOCIAL SECURITY NO.
(IF YES, GIVE WAR OR DATES)
176 10 8534 | 17. INFORMANT ADDRESS
Thomas W. Himes, Husband Same | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) CARDIO-RESPIRATORY ARREST
1539
DUE TO, OR AS A CONSEQUENCE OF
(b) ADVANCE CARCINOMATOSIS
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO, OR AS A CONSEQUENCE OF
(c) CARCINOMA OF THE COLON (MULTIPLE) | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
1 year
1977 |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)
CANCER OF BREAST, CANCER OF CERVIX | | | | |
| 19a. DATE OF OPERATION
9/14/81 | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED
Recurrent carcinoma of colon with | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input type="checkbox"/> | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER)
N/A | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
N/A | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I, OR PART 2)
N/A | | |
| 21d. INJURY OCCURRED
WHILE AT WORK <input type="checkbox"/> N/A
AT WORK <input type="checkbox"/> | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)
N/A | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE
N/A | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 2/15/82 , 19 82 , to 2/16 , 19 82 , that (I) (we) last saw the deceased alive on 2/15 , 19 82 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | |
| 22b. SIGNATURE
Chatchaval Vuthiganon | DEGREE
MD | ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> | 22c. DATE SIGNED
2/16/82 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
CHATCHAVAL VUTHIGANON | | 22e. ADDRESS
NORTH CHARLES GENERAL HOSPITAL, BALTO | | |
| 23a. BURIAL, CREMATION, REMOVAL
Burial | 23b. DATE
2/19/82 | 23c. NAME OF CEMETERY OR CREMATORY
Holly Hill Memorial Gardens | 23d. LOCATION
CITY OR TOWN COUNTY STATE
Baltimore Co., Md. | |
| 24. FUNERAL DIRECTOR
NAME ADDRESS
Bruzdziński Funeral Home PA 1407 Old Eastern Ave | | 25a. DATE REC'D. BY REGISTRAR
FEB 18 1982 | | |
| | | 25b. REGISTRAR'S SIGNATURE
James Jean Wether | | |

Information

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at 1-800-351-1000.

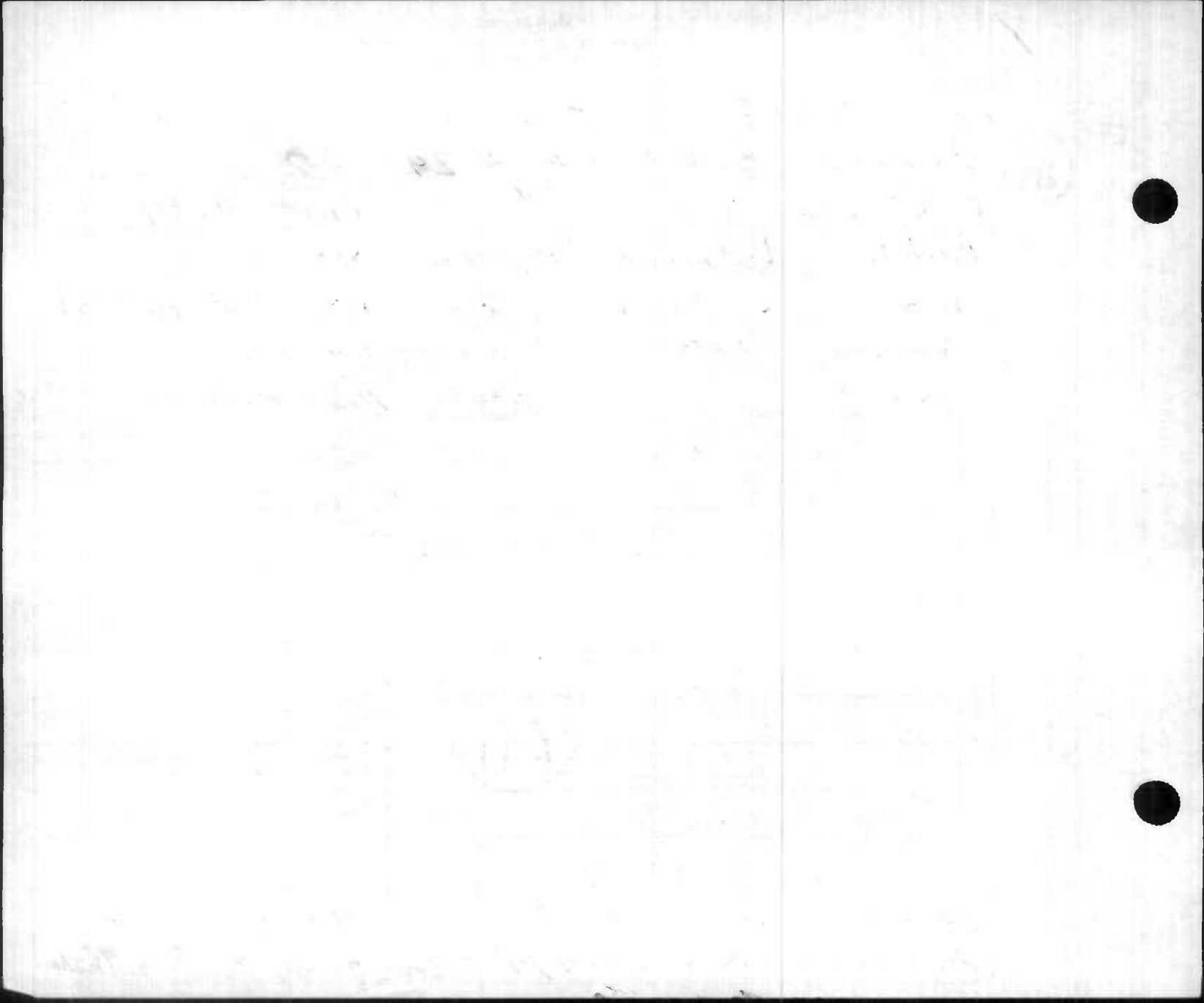
STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 2 0 3 8 3 5

1. FOR
STATE
REGISTRAR

REG. NO.

| | | | | | | | | | |
|--|--|---|--|---|--|---|--|--|--|
| 1. DECEASED NAME
(1st, middle or print) NANNIE IRENE FIRST HINTON MIDDLE LAST | | | | 2a. DATE OF DEATH
MONTH DAY YEAR
2-28-82 | | | | 2b. HOUR
1 ⁴⁰ P.M. | |
| 3. SEX
FEMALE | | 4. RACE
BLACK | | 5. DATE OF BIRTH
MONTH DAY YEAR
4 4 29 | | 6. AGE (IN YEARS LAST BIRTHDAY)
52 YRS. | | IF UNDER 1 YEAR
MONTHS DAYS HOURS MIN. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
NORTH CAROLINA | | 7b. CITIZEN OF WHAT COUNTRY?
USA | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
BALTIMORE CITY MD | | | |
| 10. CITY OR TOWN OF DEATH
BALTIMORE | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
LUTHERAN HOSPITAL | | | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
NONE | | 12b. KIND OF BUSINESS OR INDUSTRY | |
| 13a. STATE
MD | | 13b. COUNTY
- | | 13c. CITY OR TOWN
BALTIMORE | | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS
1138 WHATCOAT ST. | |
| 14. FATHER'S NAME
FIRST QUINCY MIDDLE COLBY LAST | | | | 15. MOTHER'S MAIDEN NAME
FIRST NANCY MIDDLE CHICK LAST | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
NO | | | | 16b. SOCIAL SECURITY NO.
(IF YES, GIVE WAR OR DATES) | | 17. INFORMANT
ADDRESS
ROBERT HINTON 1138 WHATCOAT ST. | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART 1. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Cardio Respiratory Arrest
4860
DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b) Brain damage
(c) Pneumonia | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: 0 | | | | | | | | | |
| 19a. DATE OF OPERATION | | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | | | 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER NOTIFY MEDICAL EXAMINER) | | | | | |
| 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | | | |
| 21d. INJURY OCCURRED
WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | |
| 22a. I certify that (I) (this hospital) attended the deceased from 2/21/82 19 82 to 2/28/82 19 82 that (I) (we) lost saw the deceased alive on 2/28/82 19 82 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death. | | | | 22b. SIGNATURE
Dr. George Gebremariam DEGREE | | | | 22c. DATE SIGNED
2/28/82 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
Dr. George Gebremariam | | | | 22e. ADDRESS | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL
(SPR) Burial | | | | 23b. DATE
3/4/82 | | 23c. NAME OF CEMETERY OR CREMATORY
Mt Auburn | | 23d. LOCATION
OR TOWN COUNTY STATE
BALTIMORE, MD | |
| 24. FUNERAL DIRECTOR
NAME
Marshall D. Santos ADDRESS
635 N 91st Ave | | | | 25a. DATE REC'D. BY REGISTRAR
MAR 3 1982 | | 25b. REGISTRAR'S SIGNATURE
James Van Natten | | | |



STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 2 0 3 8 3 6

1 - FOR
STATE
REGISTRAR

REG. NO.

| | | | | | | |
|---|--|---|--|---|---|--|
| 1. DECEASED NAME
(TYPE OR PRINT) FIRST MIDDLE LAST
HORTENSE V. HITE | | | 2a. DATE OF DEATH MONTH DAY YEAR
2-7-1982 | | 2b. HOUR
5 P | |
| 3. SEX
Female | 4. RACE
NEGRO | 5. DATE OF BIRTH MONTH DAY YEAR
Sept. 2-1910 | 6. AGE (IN YEARS LAST BIRTHDAY)
71 YRS. | IF UNDER 1 YEAR MONTHS DAYS
IF UNDER 24 HRS. HOURS MIN. | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
VA. | 7b. CITIZEN OF WHAT COUNTRY?
U.S.A. | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 9. BALTIMORE CITY OR COUNTY OF DEATH
Baltimore City MD. | | | |
| 10. CITY OR TOWN OF DEATH
Baltimore | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
John L. Denton Med. Ctr. | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
Homemaker | 12b. KIND OF BUSINESS OR INDUSTRY
At Home | | |
| 13a. STATE
MD. | 13b. COUNTY
Baltimore | 13c. CITY OR TOWN
Baltimore | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | 13e. STREET ADDRESS
2710 Roslyn Ave. | | |
| 14. FATHER'S NAME FIRST MIDDLE LAST
John S. Harper | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST
Rebecca Crosse | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)
NO | | 16b. SOCIAL SECURITY NO.
216-095629 | 17. INFORMANT ADDRESS
John M. Hite 5639 Belle Ave. | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Myocardial Infarction
4140
DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b) _____
DUE TO, OR AS A CONSEQUENCE OF
(c) _____ | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
7 days | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)
SPCA & Hemiplegia, aphasia | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | |
| 22a. I certify that (this hospital) attended the deceased from 1/6/82 , 19 82 , to 2/7/82 , 19 82 , that (we) last saw the deceased alive on 2/7/82 , 19 82 , and that in (my/our) opinion death occurred on the date and hour and from the causes stated above. (I/we) (did) (did not) view the body after death. | | | | | | |
| 22b. SIGNATURE
DR. Gladys, MD | | | DEGREE | 22c. DATE SIGNED
2/8/82 | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) | | | 22e. ADDRESS | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)
Burial | 23b. DATE
2-11-82 | 23c. NAME OF CEMETERY OR CREMATORY
Woodlawn Cnty. | | 23d. LOCATION CITY OR TOWN COUNTY STATE
Baltimore MD. | | |
| 24. FUNERAL DIRECTOR NAME
Randolph J. Collick | | | 25a. DATE REC'D. BY REGISTRAR
FEB 9 1982 | | | |
| ADDRESS
2436 Oliver St. | | | 25b. REGISTRAR'S SIGNATURE
Theresa J. [Signature] | | | |

(101)

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be retained by the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

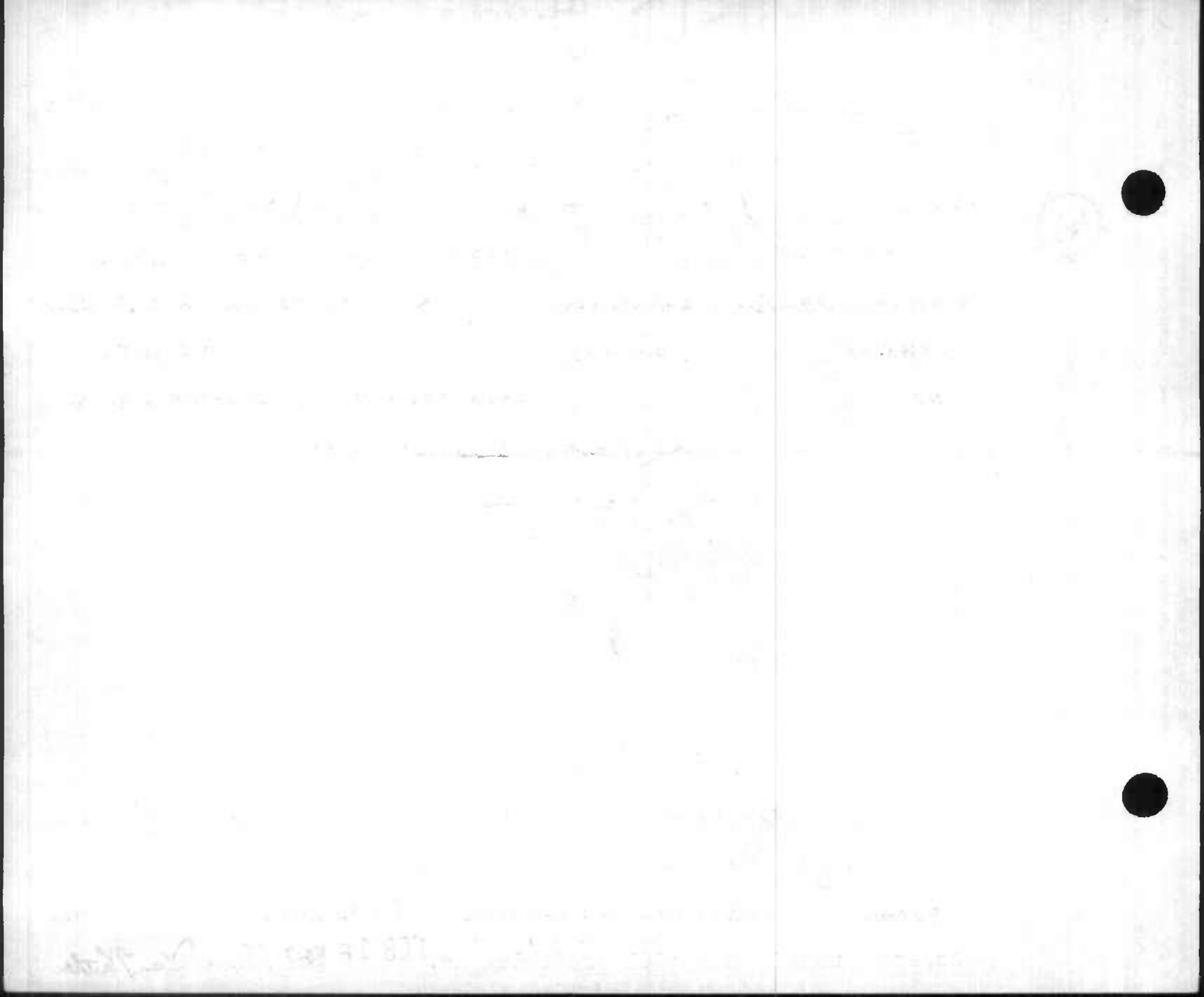
1. FOR
STATE
REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 2 0 3 8 3 7

REG. NO.

| | | | | | |
|--|-----------------------------|---|--|--|--|
| 1. DECEASED NAME
(TYPE OR PRINT) Laurel L. Hobbs | | | 2a. DATE OF DEATH
MONTH DAY YEAR
02 15 82 | | 2b. HOUR
4¹⁰ A.M. |
| 3. SEX
F | 4. RACE
Caucasian | 5. DATE OF BIRTH
MONTH DAY YEAR
05 11 83 | | 6. AGE (IN YEARS LAST BIRTHDAY)
98 YRS. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
MARYLAND | | 7b. CITIZEN OF WHAT COUNTRY?
U.S.A. | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | |
| 9. BALTIMORE CITY OR COUNTY OF DEATH
Balto. City MD. | | 10. CITY OR TOWN OF DEATH
Balto. | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
SBGH | |
| 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
HOUSEWIFE | | 12b. KIND OF BUSINESS OR INDUSTRY
HOME | | 13a. STATE
MARYLAND | |
| 13b. COUNTY
BALTO. | | 13c. CITY OR TOWN
CATONSVILLE | | 13d. INSIDE CITY LIMITS?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 13e. STREET ADDRESS
110 MELLOR AVE 21228 | | 14. FATHER'S NAME
FIRST MIDDLE LAST
CHARLES WALTERS | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
KESSLER | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
NO | | 16b. SOCIAL SECURITY NO.
(IF YES, GIVE WAR OR DATES) | | 17. INFORMANT
ADDRESS
LAWRENCE W. HOBBS SEVERNA PARK, MD | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART 1. DEATH WAS CAUSED BY:
0389 IMMEDIATE CAUSE (a) Cardio pulmonary Arrest
DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last
(b) Sepsis
DUE TO, OR AS A CONSEQUENCE OF
(c) | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | |
| 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | 21d. INJURY OCCURRED
WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | |
| 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | 22a. I certify that (I) (his hospital) attended the deceased from 2/13 19 82 to 2/15 19 82 , that (I) (we) last saw the deceased alive on 2/15 19 82 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | 22b. SIGNATURE
Jorge Vallecillo, MD DEGREE
ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> | |
| 22c. DATE SIGNED
2/15/82 | | 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
Jorge Vallecillo, MD | | 22e. ADDRESS
SBGH | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)
BURIAL | | 23b. DATE
FEB 18, 1982 | | 23c. NAME OF CEMETERY OR CREMATORY
NEW CATHEDRAL CEMETERY | |
| 23d. LOCATION
CITY OR TOWN COUNTY STATE
BALTIMORE MD. | | 24. FUNERAL DIRECTOR
NAME
MacNabb Funeral Home | | 25. DATE REC'D. BY REGISTRAR
FEB 16 1982 | |
| 25a. REGISTRAR'S SIGNATURE
James Van Natten | | 25b. REGISTRAR'S SIGNATURE | | | |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

Item 23b G 565 3/18/82 GAB

FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 2 0 3 8 3 8

REG. NO.

| | | | | | | | | | |
|--|--|--|--|---|--|--|--|--|--|
| 1. DECEASED NAME
(TYPE OR PRINT)
FIRST MIDDLE LAST
EMMA E HOBLER | | | 2a. DATE OF DEATH
MONTH DAY YEAR
2 25 82 | | | 2b. HOUR
8:05 PM | | | |
| 3. SEX
FEMALE | | 4. RACE
White | | 5. DATE OF BIRTH
MONTH DAY YEAR
2 13 1892 | | 6. AGE (IN YEARS LAST BIRTHDAY)
90 YRS. | | 7. IF UNDER 1 YEAR
MONTHS DAYS HOURS MIN.
0 12 | |
| 8a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
MARYLAND | | 8b. CITIZEN OF WHAT COUNTRY?
USA | | 9. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
BALTIMORE CITY MD. | | | |
| 10. CITY OR TOWN OF DEATH
BALTIMORE | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
SOUTH BALTIMORE GENERAL | | | | 12a. USUAL OCCUPATION
(RETIRED)
NONE - HOUSE- | | 12b. KIND OF BUSINESS OR INDUSTRY
- | |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)
13a. STATE MARYLAND | | | | 13b. CITY OR TOWN
BALTIMORE | | 13c. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
Charles Dornhecker | | | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
Sidonia L Albrecht | | 16. STREET ADDRESS
110 Michael Ave | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
UNKNOWN | | 16b. SOCIAL SECURITY NO.
219-16-9930 | | 17. INFORMANT
Mrs Ruth S Ripple | | 17. ADDRESS
110 Michael Ave | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART 1. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>RESPIRATORY ARREST - CARDIAC ARREST</u>
41140
DUE TO, OR AS A CONSEQUENCE OF
(b) <u>CONGESTIVE HEART FAILURE</u>
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(c) <u>ARTERIOSCLEROTIC CORONARY ARTERY DISEASE.</u> | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).
<u>POSSIBLE STAPH. PNEUMONIA.</u> | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | | |
| 21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | | | |
| 21d. INJURY OCCURRED | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | | | |
| 22a. I certify that (I) (his hospital) attended the deceased from <u>2/20</u> 19 <u>82</u> , to <u>2/25</u> 19 <u>82</u> , that (I) (we) lost saw the deceased alive on <u>2/25</u> 19 <u>82</u> , and that in my (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | |
| 22b. SIGNATURE
Gerard M. Lowder | | | | DEGREE
M.D. | | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | 22c. DATE SIGNED
2/25/82 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
GERARD MARK LOWDER | | | | 22e. ADDRESS
SOUTH BALT. GEN. HOSP. | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)
Burial | | 23b. DATE
2/25/82 | | 23c. NAME OF CEMETERY OR CREMATORY
Druid Ridge | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
Baltimore, Maryland | | | |
| 24. FUNERAL DIRECTOR
NAME
Leonard J Ruck Inc. Baltimore, Maryland | | | | 25a. DATE REC'D. BY REGISTRAR
MAR 1 1982 | | 25b. REGISTRAR'S SIGNATURE
James J. [Signature] | | | |

BP

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with 12 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

MEDICAL CERTIFICATION

| STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH | | | | | | | | | | REG. NO.
8 2 0 3 8 3 9 | | | | | | | | | | |
|---|--|---|--|--|--|--|---|--|---|--|-------------------------------|---|-------------|--|--------------------------------|--|---|--|---|--|
| 1. FOR STATE REGISTRAR | | | | | 1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST
ELI HOFFMAN | | | | | | | 2a. DATE OF DEATH MONTH DAY YEAR
2 20 82 | | | 2b. HOUR
6:44 PM | | | | | |
| 3 SEX
MALE | | 4 RACE
WHITE | | 5. DATE OF BIRTH MONTH DAY YEAR
SEPT. 5, 1897 | | 6. AGE (IN YEARS LAST BIRTHDAY)
84 YRS. | | | IF UNDER 1 YEAR
MONTHS DAYS | | IF UNDER 24 HRS
HOURS MIN. | | | | | | | | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
MARYLAND | | 7b. CITIZEN OF WHAT COUNTRY?
USA | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
BALTIMORE CITY MD. | | | | | | | | | | | | | | |
| 10. CITY OR TOWN OF DEATH
BALTIMORE | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
UNION MEMORIAL HOSPITAL | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)
OWNER | | | 12b. KIND OF BUSINESS OR INDUSTRY
RESTAURANT | | | | | | | | | | | |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) | | | | | | | | | | 13a. STATE
MARYLAND | | | 13b. COUNTY | | 13c. CITY OR TOWN
BALTIMORE | | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS
APT. 307
3900 N. CHARLES ST. #21218 | |
| 14. FATHER'S NAME FIRST MIDDLE LAST
ISAAC HERTZ HOFFMAN | | | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST
CHAYA BELLA COPELAND | | | | | | | | | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)
NO | | 16b. SOCIAL SECURITY NO.
275-05-7417A | | 17. INFORMANT MRS. MIRIAM SHAPIRO | | | 3900 N. CHARLES ST., APT. 307 | | | #21218 | | | | | | | | | | |
| 18. CAUSE OF DEATH: Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:
4289 IMMEDIATE CAUSE (a) <u>Cardiorespiratory arrest</u>
DUE TO, OR AS A CONSEQUENCE OF
(b) <u>Heart failure</u>
DUE TO, OR AS A CONSEQUENCE OF
(c) _____
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) | | | | | | | | | | | | | | | | | | | | |
| 19a. DATE OF OPERATION
NA | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | | | | | | | | | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR
A 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | | | | | | | | | | | | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION CITY OR TOWN COUNTY STATE | | | | | | | | | | | | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 1/25/82, 19 82, to 2/20, 19 82, that (I) (we) lost saw the deceased alive on 2/20, 19 82, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | | | | | | | | | | | | |
| 22b. SIGNATURE
Daniel G. Munro | | | | DEGREE
MD | | | | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | 22c. DATE SIGNED
2/20/82 | | | | | | | | | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
DANIEL G. MUNRO | | | | 22e. ADDRESS
UNION MEMO HOSP BALTO. | | | | | | | | | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)
BURIAL | | 23b. DATE
FEB. 22, 1982 | | 23c. NAME OF CEMETERY OR CREMATORY
RIGA KURLANDER VERETIN | | | 23d. LOCATION CITY OR TOWN COUNTY STATE
ROSEDALE BALTO. MD | | | | | | | | | | | | | |
| 24. FUNERAL DIRECTOR SOL LEVINSON & BROS., INC.
NAME ADDRESS
6010 REISTERSTOWN RD. BALTO., MD 21215 | | | | 25a. DATE REC'D. BY REGISTRAR
FEB 24 1982 | | 25b. REGISTRAR'S SIGNATURE
Thom Jan... | | | | | | | | | | | | | | |

UNITED STATES DEPARTMENT OF THE INTERIOR

BUREAU OF LAND MANAGEMENT

1944-45

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified in writing.

MEDICAL CERTIFICATION

| STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH | | | | | | | | | | 8 2 0 3 8 4 0 | |
|---|--|--|--|---|--|---|--|--|--|---------------|--|
| 1. FOR
STATE
REGISTRAR | | REG. NO. | | | | | | | | | |
| 1. DECEASED NAME
(TYPE OR PRINT) FIRST MIDDLE LAST
HARRY A HOFFMAN | | | | | | 2a. DATE OF DEATH MONTH DAY YEAR
2 16 82 | | 2b. HOUR
6 53 AM | | | |
| 3 SEX
MALE | | 4 RACE
CAUCASIAN | | 5. DATE OF BIRTH MONTH DAY YEAR
9 16 20 | | 6. AGE (IN YEARS LAST BIRTHDAY)
61 YRS. | | IF UNDER 1 YEAR
MONTHS DAYS
IF UNDER 24 HRS
HOURS MIN. | | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
MD | | 7b. CITIZEN OF WHAT COUNTRY?
USA | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
BALTIMORE CITY MD. | | | | | |
| 10. CITY OR TOWN OF DEATH
BALTIMORE | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
SOUTH BALTIMORE GENERAL HOSPITAL | | | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
POLICE GUARD | | 12b. KIND OF BUSINESS OR INDUSTRY
BALTO. COUNTY PURULATOR | | | |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)
13a. STATE
MD | | 13b. COUNTY
BALTIMORE | | 13c. CITY OR TOWN
BALTO. HGLDS. | | 13d. INSIDE CITY LIMITS?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 13e. STREET ADDRESS
2818 HOFFMAN AVENUE | | | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
GEORGE V. HOFFMAN | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
MARGARET BROOKS | | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)
YES WW II | | 16b. SOCIAL SECURITY NO.
213-14-9609 | | 17. INFORMANT ADDRESS
DOROTHY H. HOFFMAN 2818 HOFFMAN AVENUE 21227 | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c).)
PART 1. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Cardio respiratory failure
1539
DUE TO, OR AS A CONSEQUENCE OF
(b) Metastatic Carcinoma colon
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last
(c) Carcinoma of the colon | | | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) | | | | | | | | | | | |
| 19a. DATE OF OPERATION
2-2-82 | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED
Intra abdominal sepsis | | | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | | | | | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK AT WORK | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 1-22-82 to 2-16-82 , that (I) (we) last saw the deceased alive on 2-16-82 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | | | |
| 22b. SIGNATURE
S. Zambudio | | | | DEGREE
MD | | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> | | 22c. DATE SIGNED
2/16/82 | | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
S. ZAMUDIO E | | | | 22e. ADDRESS
3001 S. Hanover St. Baltimore MD 21220 | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)
BURIAL | | 23b. DATE
02-19-82 | | 23c. NAME OF CEMETERY OR CREMATORY
CREST LAWN MEM. GAR. | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
MARRIOTTSTVILLE HOWARD MD. | | | | | |
| 24. FUNERAL DIRECTOR
NAME ADDRESS
HUBBARD FUNERAL HOME, INC. 4107 WILKENS AVE. 21229 | | | | 25a. DATE REC'D. BY REGISTRAR
FEB 19 1982 | | | | | | | |
| 25b. REGISTRAR'S SIGNATURE
James J. Nathan | | | | | | | | | | | |

[Faint, mostly illegible handwritten text, likely bleed-through from the reverse side of the page. The text appears to be organized into several paragraphs and possibly a list or table structure.]

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be received within 24 hours after death. Page 4 must be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbonpapers, Pages 1 and 2 should be filed in the office of the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

FOR
1 - STATE
REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 2 0 3 8 4 1

REG. NO.

| | | | | | | | | | | | |
|--|--|--|--|---|--|---|--|--|--|--|--|
| 1. DECEASED NAME
(TYPE OR PRINT)
Johnnie | | FIRST
Holley | | LAST
(Holly) | | 2a. DATE OF DEATH
2-28-82 | | MONTH DAY YEAR | | 2b. HOUR
4:35P | |
| 3. SEX
Male | | 4. RACE
Black | | 5. DATE OF BIRTH
7 30 25 | | 6. AGE (IN YEARS LAST BIRTHDAY)
56 | | IF UNDER 1 YEAR
MONTHS DAYS | | IF UNDER 24 HRS.
HOURS MIN. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
S.C. | | 7b. CITIZEN OF WHAT COUNTRY?
USA | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
Baltimore City MD. | | | | | |
| 10. CITY OR TOWN OF DEATH
Baltimore | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
Johns Hopkins Hospital | | | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE) | | 12b. KIND OF BUSINESS OR INDUSTRY | | | |
| 13a. STATE
MD | | 13b. COUNTY | | 13c. CITY OR TOWN
Baltimore | | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS
910 N. Chester St. | | | |
| 14. FATHER'S NAME
FIRST Junior MIDDLE LAST Copper | | 15. MOTHER'S MAIDEN NAME
FIRST Louise MIDDLE LAST Hill | | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN) Yes | | 16b. SOCIAL SECURITY NO.
239-34-5937 | | 17. INFORMANT ADDRESS
Andy Hill 2705 Delk Ct. | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART 1. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) cardiorespiratory arrest
1509
DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b) septic shock
DUE TO, OR AS A CONSEQUENCE OF
(c) extensive terminal esophageal cancer | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
immediate
8 hours
unknown | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) | | | | | | | | | | | |
| 19a. DATE OF OPERATION
2/24/82 | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED
esophageal cancer | | | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | | | | | |
| 21d. INJURY OCCURRED
WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 2/5/82 , 19 82 , to 2/28 , 19 82 , that (I) (we) last saw the deceased alive on 2/28 , 19 82 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | | | |
| 22b. SIGNATURE
Keith D. Osborn | | DEGREE
MD | | ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> | | 22c. DATE SIGNED
2/28/82 | | | | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
Keith D. Osborn | | 22e. ADDRESS
Johns Hopkins Hospital, Balto. Md | | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)
Burial | | 23b. DATE
3/5/82 | | 23c. NAME OF CEMETERY OR CREMATORY
Md. Veteran Cem. | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
Crownsville MD | | | | | |
| 24. FUNERAL DIRECTOR
NAME
Wm. C. March F/H | | 1101 E. North Ave. | | 25a. DATE REC'D. BY REGISTRAR
MAR 2 1982 | | 25b. REGISTRAR'S SIGNATURE
James J. W. W. W. | | | | | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed in the office of the Registrar after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

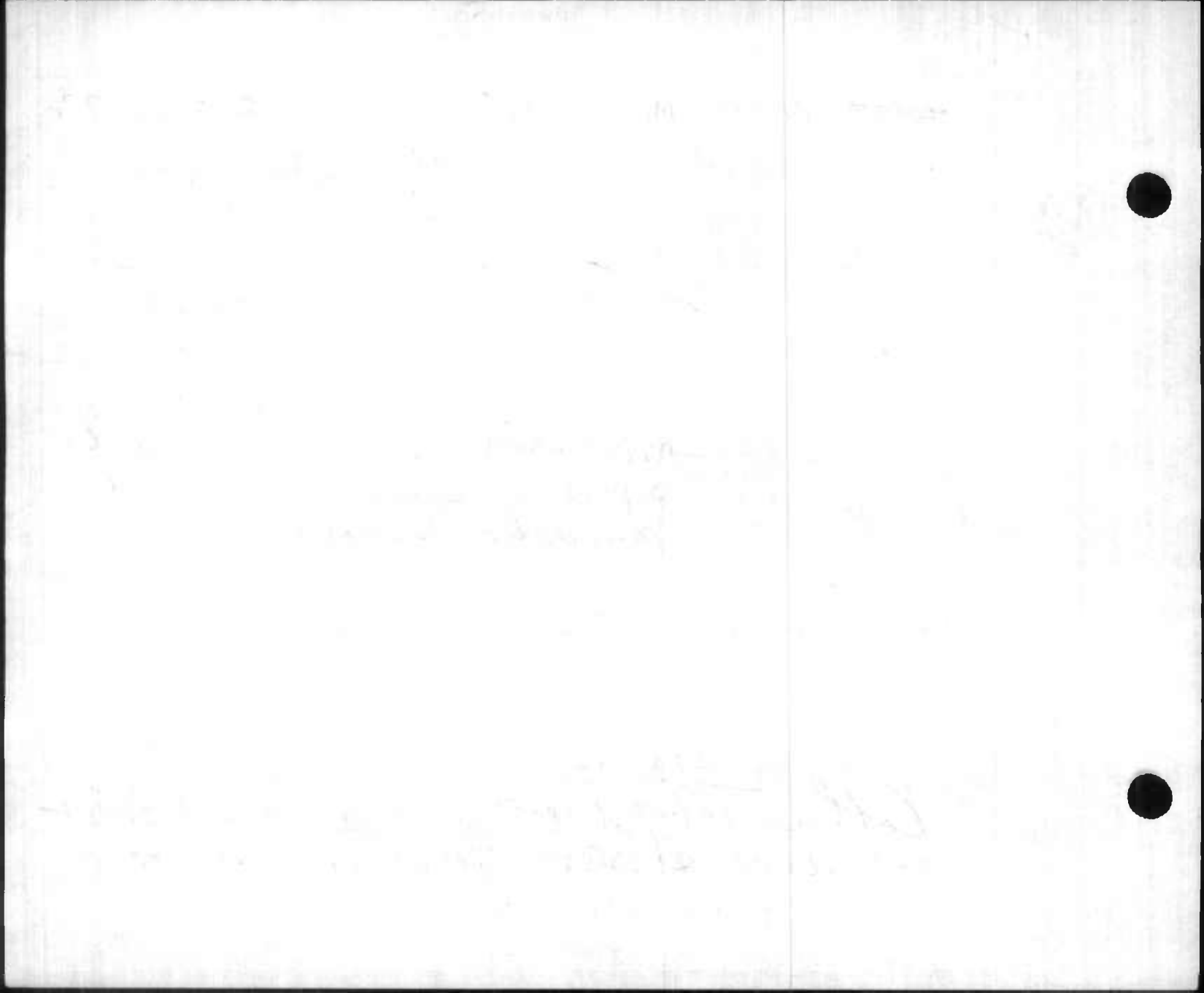
FOR
1- STATE
REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 2 0 3 8 4 2

REG. NO.

| | | | | | |
|---|-------------------------------------|---|---|--|--|
| 1. DECEASED NAME
(TYPE OR PRINT) HOLLIE ANNA M. HOLLIE | | | 2a. DATE OF DEATH
MONTH DAY YEAR
2 3 82 | | 2b. HOUR
7:30 P.M. |
| 3. SEX
F | 4. RACE
B | 5. DATE OF BIRTH
MONTH DAY YEAR
2 9 42 | | 6. AGE (IN YEARS LAST BIRTHDAY)
39 YRS. | IF UNDER 1 YEAR
MONTHS DAYS
IF UNDER 24 HRS.
HOURS MIN. |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
S.C. | 7b. CITIZEN OF WHAT COUNTRY?
USA | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 9. BALTIMORE CITY OR COUNTY OF DEATH
Baltimore City MD | | |
| 10. CITY OR TOWN OF DEATH
Baltimore | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
Baltimore City Hosp. | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE) | 12b. KIND OF BUSINESS OR INDUSTRY |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) | | | | | |
| 13a. STATE
MD | 13b. COUNTY | 13c. CITY OR TOWN
Baltimore | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | 13e. STREET ADDRESS
2402 E. Federal St. | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
Junious Hollie | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
Louise Dundee | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
No | | 16b. SOCIAL SECURITY NO.
N/A | 17. INFORMANT
ADDRESS
Betty Hollie 2402 E. Federal St. | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>hypotension</u>
5778 DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>sepsis</u>
(c) <u>pancreatic necrosis</u> | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
15d
15d |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a):
NONE | | | | | |
| 19a. DATE OF OPERATION
1/21/82 + 1/28 | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED
abdominal sepsis | | 20a. AUTOPSY?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK | | 21e. PLACE OF INJURY
(AT HOME STREET FACTORY OFFICE FARM, ETC.) | | 21f. LOCATION
CITY OR TOWN COUNTY STATE | |
| 22a. I certify that (I) (this hospital) attended the deceased from 1/17 19 82 to 2/3 19 82 that (I) (we) last saw the deceased alive on 2/3 19 82 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death. | | | | | |
| 22b. SIGNATURE
KATHLEEN BRELSTORD | | DEGREE
MD | | 22c. DATE SIGNED
2/3/82 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
KATHLEEN BRELSTORD | | 22e. ADDRESS
BALTIMORE CITY MD | | | |
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)
Burial | | 23b. DATE
2/9/82 | 23c. NAME OF CEMETERY OR CREMATORY
Mt. Auburn Cem. | | 23d. LOCATION
Baltimore COUNTY MD |
| 24. FUNERAL DIRECTOR
NAME
Wm. C. March F/H | | ADDRESS
1101 E. North Ave. | | 25a. DATE REC'D. BY REGISTRAR
FEB 5 1982 | 25b. REGISTRAR'S SIGNATURE
Anne J. [Signature] |



TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 48 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

MEDICAL CERTIFICATION

| STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH | | | | | | | | | | REG. NO. 5 2 0 3 8 4 3 | |
|---|--|------------------|--|---|--|--|--|--|--|---|--|
| 1. FOR REGISTRAR | | | | | | | | | | | |
| 1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST
Raymond Holloway (Hollaway) | | | | | | | | | | 20. DATE KNOWN OF DEATH ESTIMATED <input checked="" type="checkbox"/> MONTH DAY YEAR 2 22 19 82 | |
| 3. SEX
Male | | 4. RACE
Black | | 5. DATE OF BIRTH MONTH DAY YEAR 3 3 21 | | 6. AGE (IN YEARS LAST BIRTHDAY) 61 YRS. | | IF UNDER 1 YR. MONTHS DAYS HOURS MIN. | | 21. DATE PRONOUNCED DEAD MONTH DAY YEAR 2 22 19 82 | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
S.C. | | | | 7b. CITIZEN OF WHAT COUNTRY?
USA | | | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
Baltimore City, MD. | |
| 10. CITY OR TOWN OF DEATH
Baltimore | | | | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
1908 N. Charles Street | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | | 12b. KIND OF BUSINESS OR INDUSTRY | |
| USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) | | | | | | | | | | | |
| 13a. STATE
Md. | | 13b. COUNTY | | 13c. CITY OR TOWN
Balto. | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS
1908 N. Charles St. | | | |
| 14. FATHER'S NAME FIRST MIDDLE LAST
Tom Holloway | | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST
Martha Evans | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)
No | | | | 16b. SOCIAL SECURITY NO. | | 17. INFORMANT ADDRESS
Bernetha Holloway 102 Gallows Gate Darlington, S.C. | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>Arteriosclerotic cardiovascular disease</u>
4292
Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.
(b) _____
(c) _____
DUE TO, OR AS A CONSEQUENCE OF
DUE TO, OR AS A CONSEQUENCE OF | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a). | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | | | | | | 20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH | | | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) | | | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK | | | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | | | |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural cause <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> . | | | | | | | | | | | |
| ACTUAL SIGNATURE <u>H R Guard</u> | | | | TITLE (SPECIFY) M.D. Assistant | | | | MEDICAL EXAMINER DATE SIGNED 2/22/82 | | | |
| EXAMINER'S NAME (TYPE OR PRINT) Hormez R. Guard, M.D. | | | | ADDRESS 111 Penn St. Balto., MD. | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | | | | 23b. DATE 3/1/82 | | 23c. NAME OF CEMETERY OR CREMATORY Lawson Grove Cem. | | 23d. LOCATION CITY OR TOWN COUNTY STATE Darlington, S.C. | | | |
| 24. FUNERAL DIRECTOR NAME Wm C March F/H ADDRESS 1101 E. North Ave. | | | | | | 25a. DATE REC'D. BY REGISTRAR FEB 26 1982 | | 25b. REGISTRAR'S SIGNATURE <u>James J. Nathan</u> | | | |

27 - 111

1945 - 1946

111

1947 - 1948

1949 - 1950

1951 - 1952

1953 - 1954

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. FOR
STATE
REGISTRAR

| | | | | | |
|--|--|---|--|---|--|
| 1. DECEASED NAME
(TYPE OR PRINT)
FIRST MIDDLE LAST
Helen Holmes | | | 2a. DATE OF DEATH
MONTH DAY YEAR
2 1 82 | | 2b. HOUR
M |
| 3. SEX
female | 4. RACE
black | 5. DATE OF BIRTH
MONTH DAY YEAR
5 25 03 | | 6. AGE (IN YEARS LAST BIRTHDAY)
78 YRS. | IF UNDER 1 YEAR
MONTHS DAYS
IF UNDER 24 HRS.
HOURS MIN. |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
MD | 7b. CITIZEN OF WHAT COUNTRY?
USA | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
Baltimore city MD. | |
| 10. CITY OR TOWN OF DEATH
Baltimore | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
3205 Clifton Avenue | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE) | | 12b. KIND OF BUSINESS OR INDUSTRY |
| 13a. STATE
MD | | 13b. COUNTY | 13c. CITY OR TOWN
Baltimore | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
George Johnson | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
Mary Johnson | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
No | | 16b. SOCIAL SECURITY NO.
(IF YES, GIVE WAR OR DATES)
216-10-1184 | | 17. INFORMANT
ADDRESS
Casper Holmes 3205 Clifton Avenue | |

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART 1. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a)

4360

DUE TO, OR AS A CONSEQUENCE OF

Conditions, if any, which
gave rise to immediate
cause (a), stating the
underlying cause last

(b)

DUE TO, OR AS A CONSEQUENCE OF

(c)

APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATH

instant

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)

Diabetes Mellitus

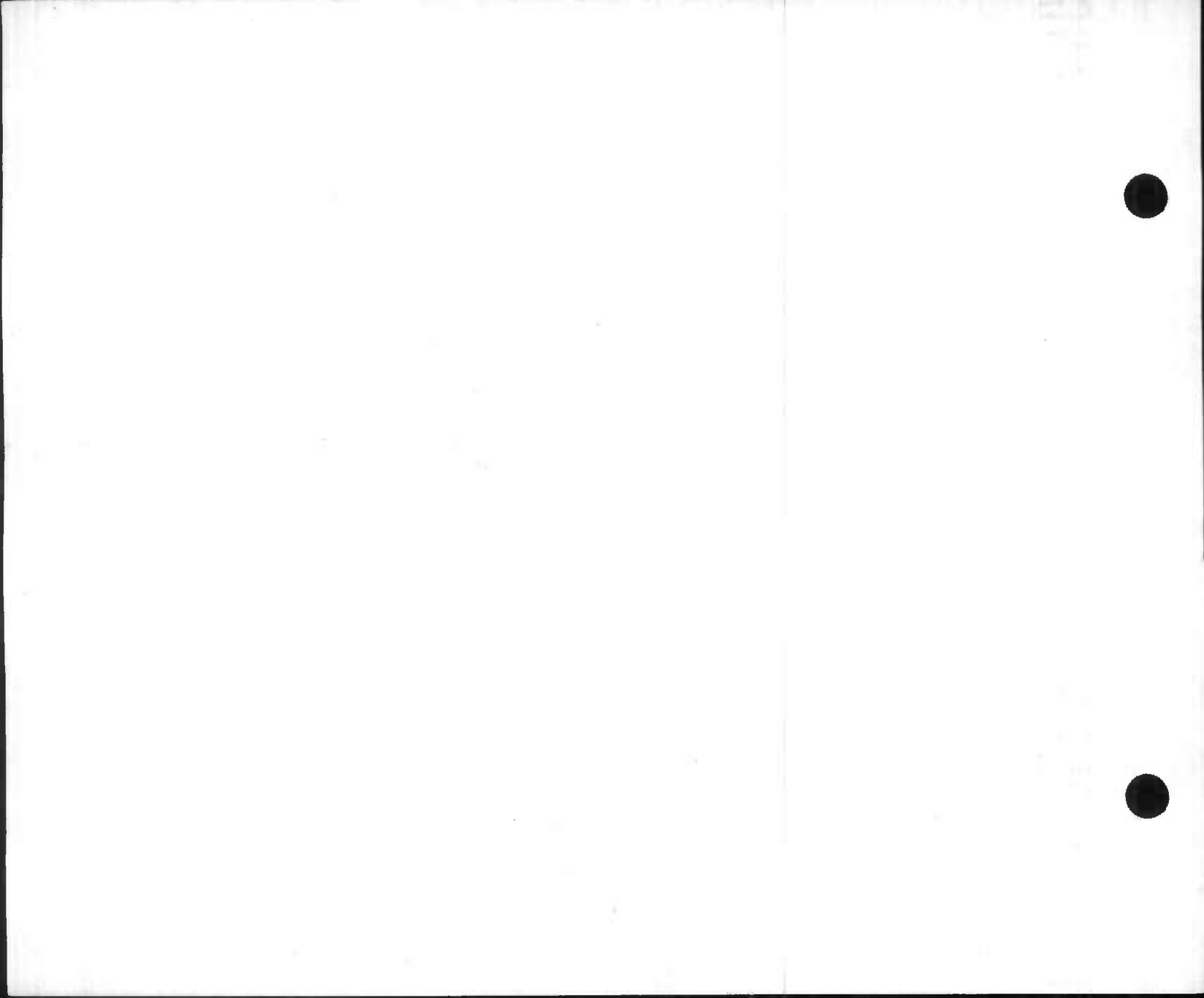
| | | | | | |
|---|--|--|--|--|---|
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input type="checkbox"/> | 20b. IF YES, WERE FINDINGS USED
IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | |
| 22a. I certify that (I) (this hospital) attended the deceased from 1/30 19 82 to 2/1 19 82, that (I) (we) last saw the deceased alive on 1/30 19 82, and that (my) (our) opinion death occurred on the date and hour and from the causes stated above (I) (we) (did) (did not) view the body after death. | | | | | |
| 22b. SIGNATURE
Herbert G. Chisell MD | | | | 22c. DATE SIGNED
2/2/82 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
Herbert G. Chisell MD | | | | 22e. ADDRESS
11 E. Chase St Baltimore 21202 | |

| | | | |
|---|---------------------|---|--|
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)
Burial | 23b. DATE
2/6/82 | 23c. NAME OF CEMETERY OR CREMATORY
Western Star Cem. | 23d. LOCATION
CITY OR TOWN COUNTY STATE
Baltimore Co. MD |
| 24. FUNERAL DIRECTOR
NAME
William C. March F/H 1101 E. North Avenue | | 25a. DATE REC'D. BY REGISTRAR
FEB 3 1982 | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at 1-800-368-2837.

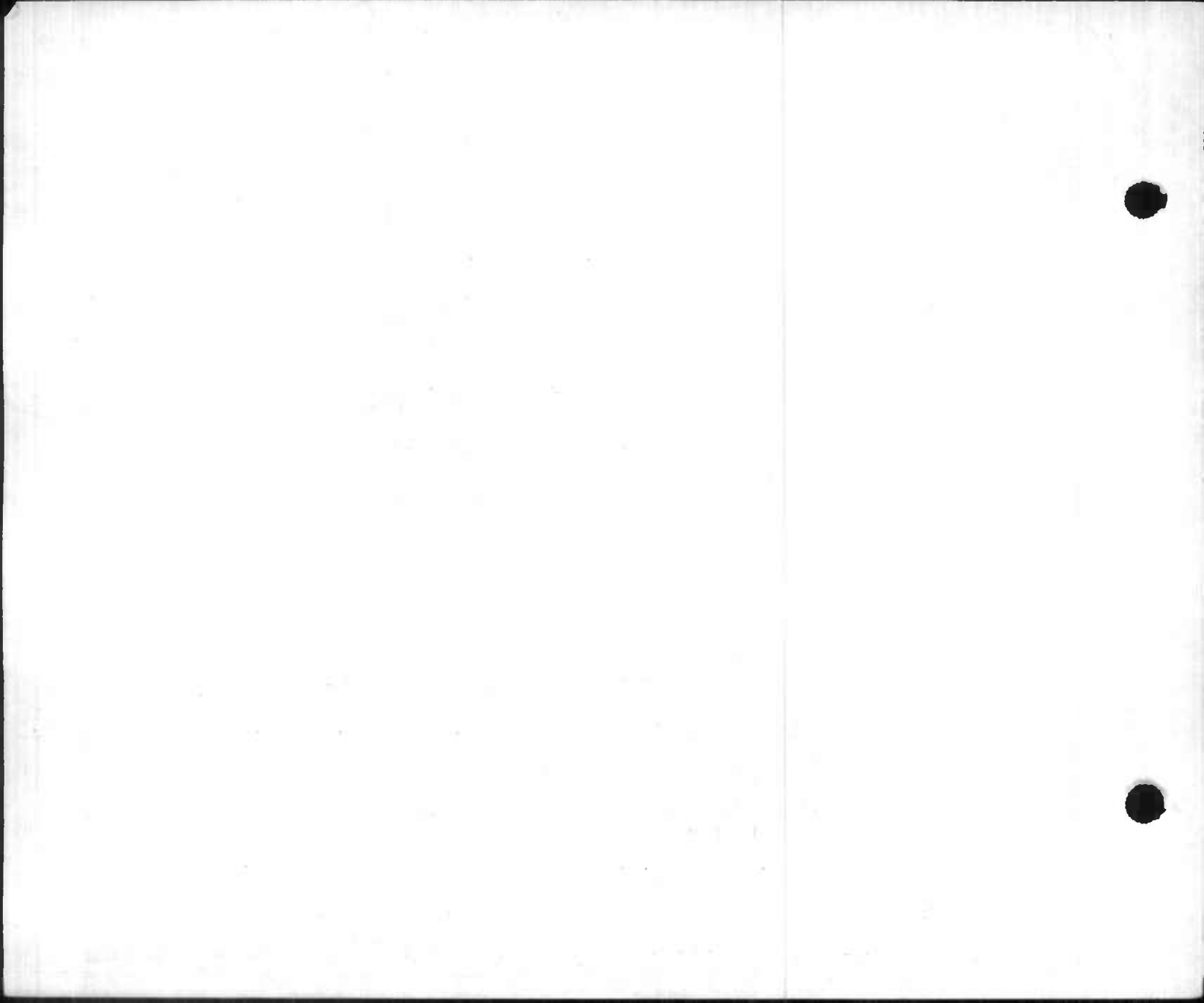


TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING TO THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 24 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 2 0 3 8 4 5

| | | | | | | | | | | | | |
|--|---------|---|--|--|--------|---|----------------------------|---------------------|---|--------------------------|---------|----------|
| 1- FOR STATE REGISTRAR | | 1. DECEASED NAME
(TYPE OR PRINT) | | FIRST | MIDDLE | LAST | 2a. DATE KNOWN OF DEATH | | <input checked="" type="checkbox"/> MONTH | DAY | YEAR | 2b. HOUR |
| | | MICHAEL A. HOLMES | | | | | 2. DATE OF ESTIMATED DEATH | | <input type="checkbox"/> 2 | 6 | 19 82 | M |
| 3. SEX | 4. RACE | 5. DATE OF BIRTH | | MONTH | DAY | YEAR | 6. AGE (IN YEARS) | IF UNDER 1 YR. | IF UNDER 24 HRS. | 7c. DATE PRONOUNCED DEAD | | 2d. HOUR |
| male | negro | 10 29 60 | | | | | 21 YRS. | MONTHS | DAYS | 2 | 6 19 82 | 1:10 a M |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) | | 7b. CITIZEN OF WHAT COUNTRY? | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH | | | | | | |
| MD | | USA | | | | Baltimore City | | MD. | | | | |
| 10. CITY OR TOWN OF DEATH | | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | | 12b. KIND OF BUSINESS OR INDUSTRY | | | | | | |
| Baltimore | | front of 2106 Mt. Holly St. | | | | | | | | | | |
| 13a. STATE | | 13b. COUNTY | | 13c. CITY OR TOWN | | 13d. INSIDE CITY LIMITS? | | 13e. STREET ADDRESS | | | | |
| MD | | | | Baltimore | | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 3908 Norfolk Avenue | | | | |
| 14. FATHER'S NAME | | 15. MOTHER'S MAIDEN NAME | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT | | ADDRESS | | | | |
| FLOYD | | EDITH | | 212-80-3527 | | Edith P. Holmes | | 3908 Norfolk Ave. | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) | | 16b. SOCIAL SECURITY NO. | | 17. INFORMANT | | ADDRESS | | | | | | |
| No | | 212-80-3527 | | Edith P. Holmes | | 3908 Norfolk Ave. | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) | | | | | | | | | | | | |
| PART I DEATH WAS CAUSED BY: | | | | | | | | | | | | |
| IMMEDIATE CAUSE (a) Gunshot wound of head (handgun) | | | | | | | | | | | | |
| 9650 | | | | | | | | | | | | |
| Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause lost. | | | | | | | | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF | | | | | | | | | | | | |
| (b) | | | | | | | | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF | | | | | | | | | | | | |
| (c) | | | | | | | | | | | | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a). | | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | | 20. AUTOPSY? | | | | | | | | |
| | | | | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | | | | | | |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2) | | | | | | | | |
| | | XMX 2-6- 19 82 | | Subject was shot. | | | | | | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) | | 21f. LOCATION | | CITY OR TOWN | | COUNTY | | STATE | | |
| | | sidewalk | | 2106 Mt. Holly St. Balto. | | | | | | Md. | | |
| 22a. I certify that I took charge of the remains described above, held on death resulted from: | | | | | | | | | | | | |
| Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input checked="" type="checkbox"/> Undetermined manner <input type="checkbox"/> | | | | | | | | | | | | |
| ACTUAL SIGNATURE | | TITLE (SPECIFY) | | DATE SIGNED | | | | | | | | |
| | | M.D. Assistant | | 2-6-82 | | | | | | | | |
| EXAMINER'S NAME (TYPE OR PRINT) | | ADDRESS | | DATE SIGNED | | | | | | | | |
| Ann M. Dixon, M.D. | | 111 Penn St. | | | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) | | 23b. DATE | | 23c. NAME OF CEMETERY OR CREMATORY | | 23d. LOCATION | | COUNTY | | STATE | | |
| Burial | | 2/12/82 | | Arbutus Mem. Park | | Baltimore | | Co. | | MD | | |
| 24. FUNERAL DIRECTOR | | 25a. DATE REC'D BY REGISTRAR | | 25b. REGISTRAR'S SIGNATURE | | | | | | | | |
| NAME | | ADDRESS | | FEB 10 1982 | | | | | | | | |
| Wm. C. March F/H | | 1101 E. North Ave. | | | | | | | | | | |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 24 hours of death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

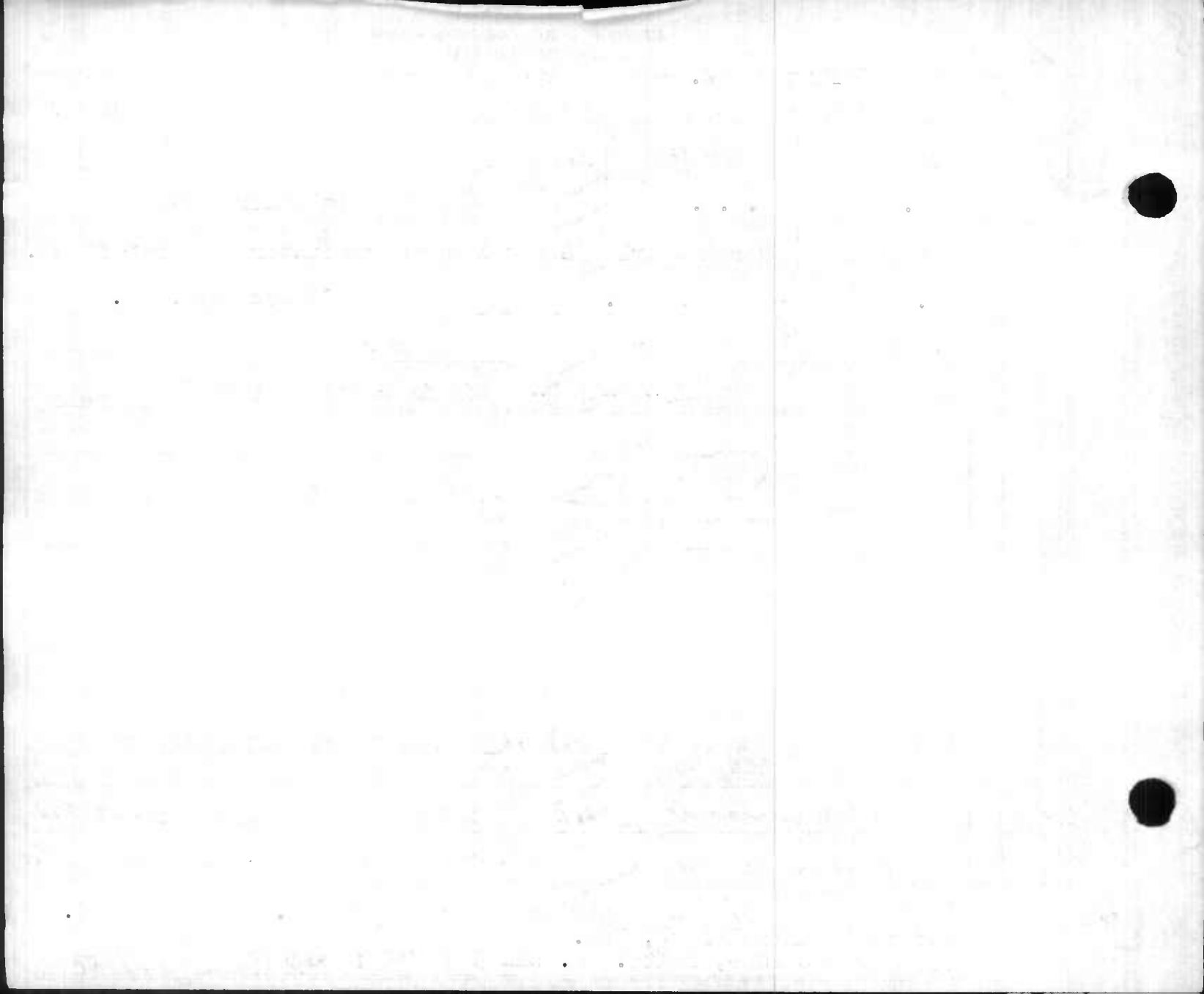
IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1 - FOR
STATE
REGISTRAR

| | | | | | |
|---|---|---|---|---|--|
| 1. DECEASED NAME
(TYPE OR PRINT)
Philip J. Holthaus
PHILIP J. HOLTHAUS | | 2a. DATE OF DEATH
MONTH DAY YEAR
FEB - 26 1982 | | 2b. HOUR
10:50 AM | |
| 3. SEX
MALE | 4. RACE
WHITE | 5. DATE OF BIRTH
MONTH DAY YEAR
APRIL 26 1900 | | 6. AGE (IN YEARS LAST BIRTHDAY)
81 YRS | |
| 7a. BIRTHPLACE
(STATE OR FOREIGN COUNTRY)
Md. | 7b. CITIZEN OF WHAT COUNTRY?
U.S.A. | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
Baltimore City MD. | |
| 10. CITY OR TOWN OF DEATH
Baltimore | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
North Charles General Hosp | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
Conductor | | 12b. KIND OF BUSINESS OR INDUSTRY
Transit Co. |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)
13a. STATE
Md. | | 13b. COUNTY
- | 13c. CITY OR TOWN
Balto. | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
John Holthaus | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
Theresa Brunning | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
no | | 16b. SOCIAL SECURITY NO.
(IF YES, GIVE WAR OR DATES)
213-10-2509-A | | 17. INFORMANT
ADDRESS
same address | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART 1. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) SEPSIS
7070
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.
(b) DUE TO, OR AS A CONSEQUENCE OF
DECUBITUS ULCERS & UTI
(c) DUE TO, OR AS A CONSEQUENCE OF | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a):
DM RENAL FAILURE | | | | | |
| 19a. DATE OF OPERATION / | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> AT WORK
NOT WHILE <input type="checkbox"/> AT WORK | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | |
| 22a. I certify that (I) (this hospital) attended the deceased from FEB-12, 19 82, to FEB-26, 19 82, that (I) (we) lost saw the deceased alive on FEB-26, 19 82, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | |
| 22b. SIGNATURE
C. VERGARA - SOARES | | DEGREE
MD | | 22c. DATE SIGNED
2-26-82 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
C. VERGARA - SOARES | | 22e. ADDRESS
N-CHARLES GEN. HOSP. BALTO. MD. 21208 | | | |
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)
Burial | | 23b. DATE
3/1/82 | | 23c. NAME OF CEMETERY OR CREMATORY
Holy Redeemer | |
| 23d. LOCATION
CITY OR TOWN
Balto. | | COUNTY
Md. | | STATE | |
| 24. FUNERAL HOME, INC.
NAME
Schimmek Funeral Home, Inc.
2331 Brehms Lane, Balto. Md. 21213 | | 25a. DATE REC'D. BY REGISTRAR
MAR 1 1982 | | 25b. REGISTRAR'S SIGNATURE
Charles J. Martin | |



TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

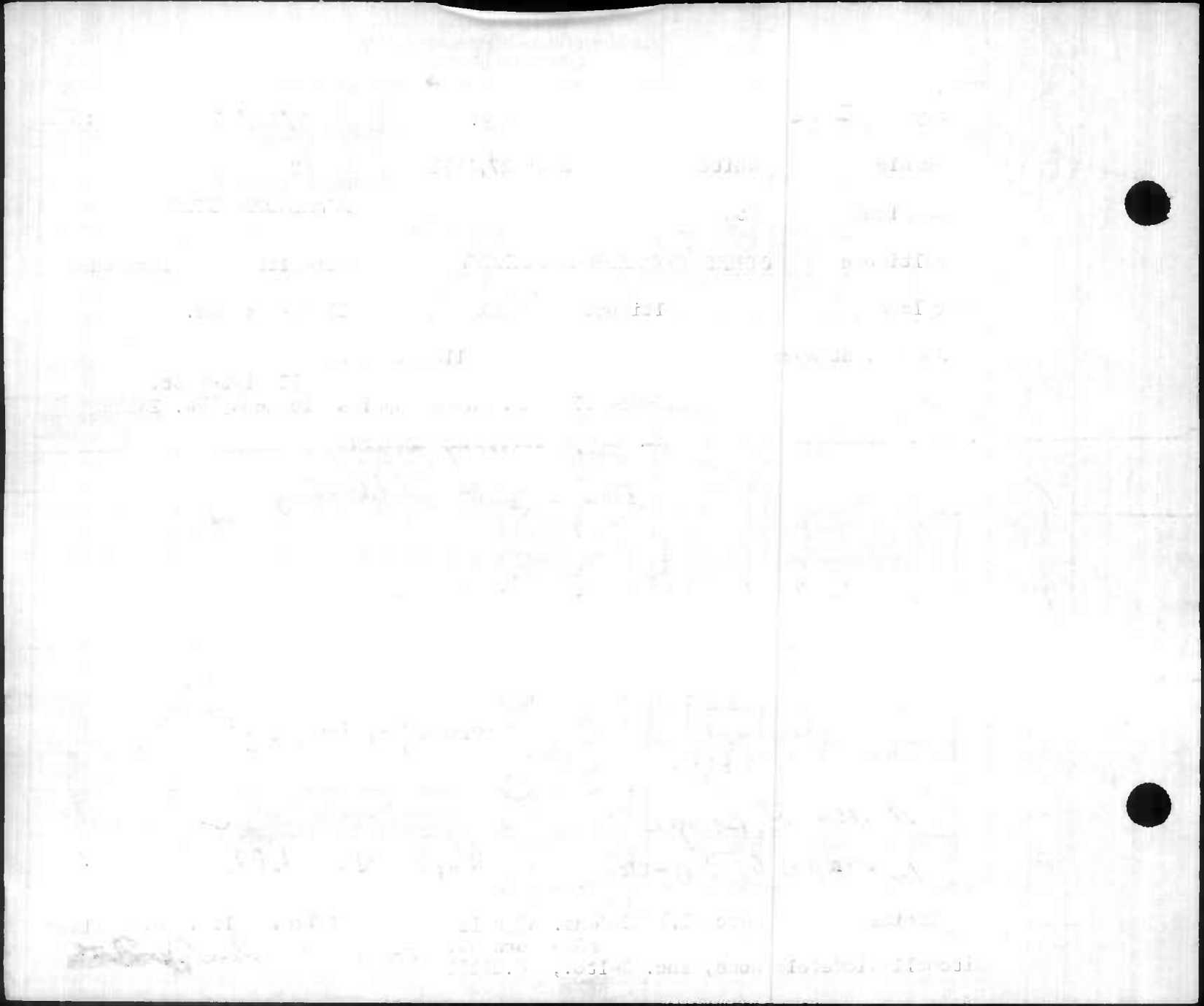
IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1. FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

8 2 0 3 8 4 7

| | | | | | | | | | | |
|---|--|---|--|---|--|--|---|--|--|--|
| 1. DECEASED NAME
(TYPE OR PRINT)
Mary Inez Hopkins | | | 2a. DATE OF DEATH
MONTH DAY YEAR
2/28/82 | | | 2b. HOUR
7:57A _M | | | | |
| 3. SEX
Female | | 4. RACE
White | | 5. DATE OF BIRTH
MONTH DAY YEAR
March 27, 1912 | | 6. AGE (IN YEARS LAST BIRTHDAY)
69 YRS. | | 7. IF UNDER 1 YEAR
MONTHS DAYS HOURS MIN. | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
Maryland | | 7b. CITIZEN OF WHAT COUNTRY?
USA | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
BALTIMORE CITY MD. | | | | |
| 10. CITY OR TOWN OF DEATH
Baltimore | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
JOHNS HOPKINS HOSPITAL | | | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
Underwriter | | 12b. KIND OF BUSINESS OR INDUSTRY
Insurance | | |
| 13a. STATE
Maryland | | | 13b. COUNTY | | 13c. CITY OR TOWN
Baltimore | | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS
5651 Purdue Ave. | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
John H. Strauch | | | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
Ella A. Hogan | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
No | | | 16b. SOCIAL SECURITY NO.
(IF YES, GIVE WAR OR DATES)
215-05-8579 | | 17. INFORMANT
2312 Wister St.
J. Wayne Hopkins Richmond, Va. 23229 | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART 1. DEATH WAS CAUSED BY
IMMEDIATE CAUSE (a) <u>Cardiopulmonary arrest</u>
1830
DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b) <u>prob 2° external bleeding</u>
DUE TO, OR AS A CONSEQUENCE OF
(c) _____ | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)
<u>Ovarian Stage III Carcinoma</u> | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | | | |
| 21d. INJURY OCCURRED
WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE
Hopkins Hospital Balt Md | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>2/27</u> , 19 <u>82</u> , to <u>2/28</u> , 19 <u>82</u> , that (I) (we) last saw the deceased alive on <u>2/28</u> , 19 <u>82</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | | |
| 22b. SIGNATURE
Nathan H. Berger | | | | | DEGREE
ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> | | 22c. DATE SIGNED
2/28/82 | | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
NATHAN G. BERGER | | | | | 22e. ADDRESS
Hopkins Hospital Balt. Md. | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)
Burial | | | 23b. DATE
March 2, 1982 | | 23c. NAME OF CEMETERY OR CREMATORY
Gdns. of Faith | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
Overlea, Balto. Co. Maryland | | | |
| 24. FUNERAL DIRECTOR
NAME ADDRESS
Mitchell-Wiedefeld Home, Inc. Balto., Md. 21212 | | | | | 25. DATE REC'D. BY REGISTRAR
MAR 2 1982 | | | | | |



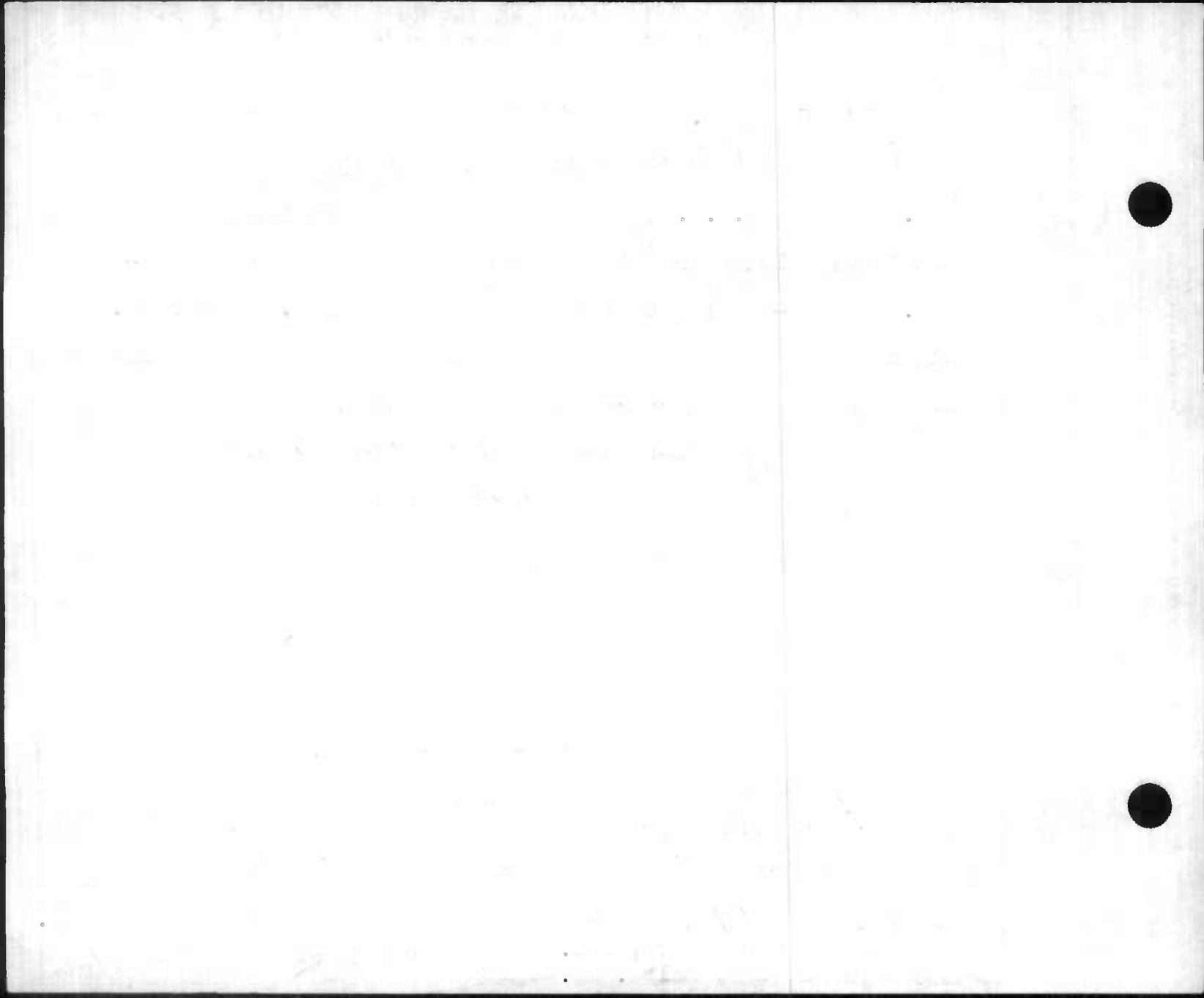
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the Registrar after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

MEDICAL CERTIFICATION

| STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH | | | | 8 2 0 3 8 4 8 | | | |
|---|--|---|--|--|--|---|--|
| 1. FOR STATE REGISTRAR | | | | REG. NO. | | | |
| 1 DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST
EDNA M. HORN | | | | 2a. DATE OF DEATH MONTH DAY YEAR
2 26 82 | | 2b. HOUR
6 05 P.M. | |
| 3 SEX
Female | | 4 RACE
Cauc | | 5 DATE OF BIRTH MONTH DAY YEAR
June 5 1928 | | 6 AGE (IN YEARS LAST BIRTHDAY) YRS MONTHS DAYS
53 | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
Md. | | 7b. CITIZEN OF WHAT COUNTRY?
U.S.A. | | 8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9 BALTIMORE CITY OR COUNTY OF DEATH
Baltimore City MD. | |
| 10 CITY OR TOWN OF DEATH
Baltimore | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
Baltimore City Hospital | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)
Homemaker | | 12b. KIND OF BUSINESS OR INDUSTRY
- | |
| 13a. STATE
Md. | | | | 13b. COUNTY
- | | 13c. CITY OR TOWN
Baltimore | |
| 14 FATHER'S NAME FIRST MIDDLE LAST
Allan Kable | | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST
Margaret Hiltner | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)
no | | | | 16b. SOCIAL SECURITY NO
217-24-4062 | | 17 INFORMANT ADDRESS
Melissa Horn (dghtr) same address | |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1 DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>Respiratory and cardiac arrest</u>
4310
DUE TO, OR AS A CONSEQUENCE OF (b) <u>cerebral bleed</u>
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO, OR AS A CONSEQUENCE OF (c)
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a): | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>2/6</u> 19 <u>82</u> , to <u>2/26</u> 19 <u>82</u> , that (I) (we) last saw the deceased alive on <u>19</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | |
| 22b. SIGNATURE
Lucien Levy | | | | DEGREE MD
ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> | | 22c. DATE SIGNED
2/26/82 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
LUCIEN LEVY | | | | 22e. ADDRESS
Baltimore City Hospital | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)
Burial | | 23b. DATE
3/2/82 | | 23c. NAME OF CEMETERY OR CREMATORY
Gardens of Faith | | 23d. LOCATION CITY OR TOWN COUNTY STATE
Baltimore Md. | |
| 24. FUNERAL DIRECTOR
Schimunek Funeral Home, Inc.
3331 Brehms Lane, Balt., Md. 21213 | | | | 25a. DATE REC'D. BY REGISTRAR
MAR 1 1982 | | 25b. REGISTRAR'S SIGNATURE
Francis Van Natten | |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of the event.

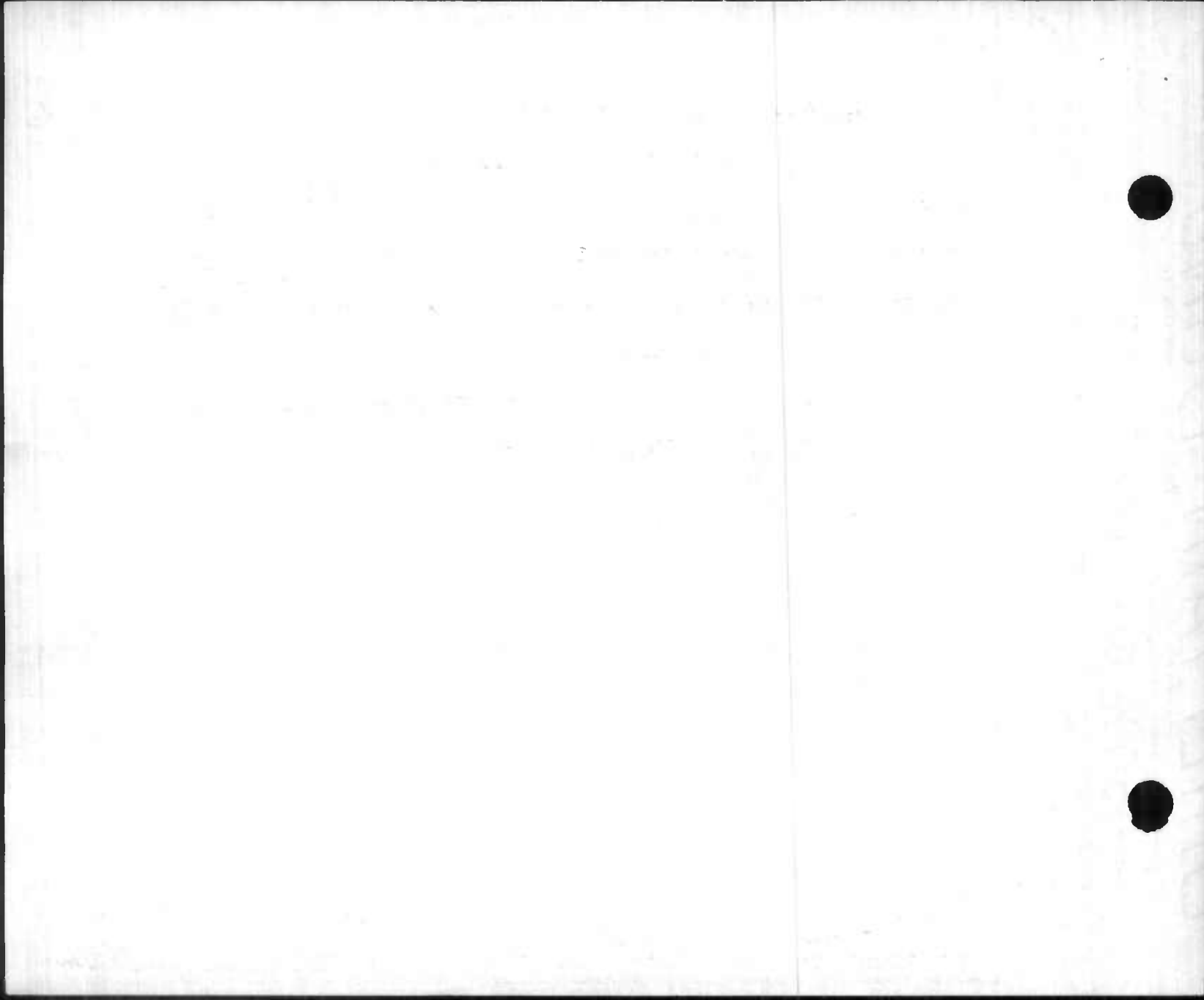
STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 2 0 3 8 4 9

REG. NO.

1- FOR
STATE
REGISTRAR

| | | | | | |
|--|-------------------------|--|---|--|----------------------------|
| 1. DECEASED NAME
(TYPE OR PRINT) ALLEN Earl HORNER | | | 2a. DATE OF DEATH
MONTH DAY YEAR
2 27 82 | | 2b. HOUR
4:15 AM |
| 3. SEX
Male | 4. RACE
WHITE | 5. DATE OF BIRTH
MONTH DAY YEAR
5 24 03 | | 6. AGE (IN YEARS LAST BIRTHDAY)
78 | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
Virginia | | 7b. CITIZEN OF WHAT COUNTRY?
USA | | 9. BALTIMORE CITY OR COUNTY OF DEATH
Baltimore City MD. | |
| 10. CITY OR TOWN OF DEATH
Baltimore City | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
Sinai Hospital | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
Electrician-Refrigeration | |
| 13a. STATE
MD | | 13b. COUNTY
Balto County | | 13c. CITY OR TOWN
BALTCOUNTY | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
Unknown | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
Unknown | | 17. INFORMANT
NAME ADDRESS
Mrs. Joanne Horner
5704 The Alameda, Balto. Maryland 21239 | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
No | | 16b. SOCIAL SECURITY NO.
232-01-9206 | | 17. INFORMANT
NAME ADDRESS
Mrs. Joanne Horner
5704 The Alameda, Balto. Maryland 21239 | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART 1. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (d) PNEUMONIA
DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO, OR AS A CONSEQUENCE OF
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
2 months | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | |
| 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) | | 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK AT WORK | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | |
| 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | 22a. I certify that (I) (this hospital) attended the deceased from Jan 31 , 19 82 , to Feb 27 , 19 82 , that (I) (we) lost saw the deceased alive on Feb 27 , 19 82 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | |
| 22b. SIGNATURE
Jim | | DEGREE | | 22c. DATE SIGNED | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
LIM | | 22e. ADDRESS
SINAI HOSP OF BALTIMORE | | 22f. DATE REC'D. BY REGISTRAR | |
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)
Burial | | 23b. DATE
3-2-82 | | 23c. NAME OF CEMETERY OR CREMATORY
Lake View Mem. Park | |
| 23d. LOCATION
CITY OR TOWN COUNTY STATE
Sykesville Carroll Maryland | | 24. FUNERAL DIRECTOR
NAME ADDRESS
Loring Byers Funeral Directors, Inc.
8728 Liberty Road Randallstown, MD. 21133 | | 25. REGISTRAR'S SIGNATURE
James J. Nathan | |



TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. It may be obtained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the funeral director, page 3 with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

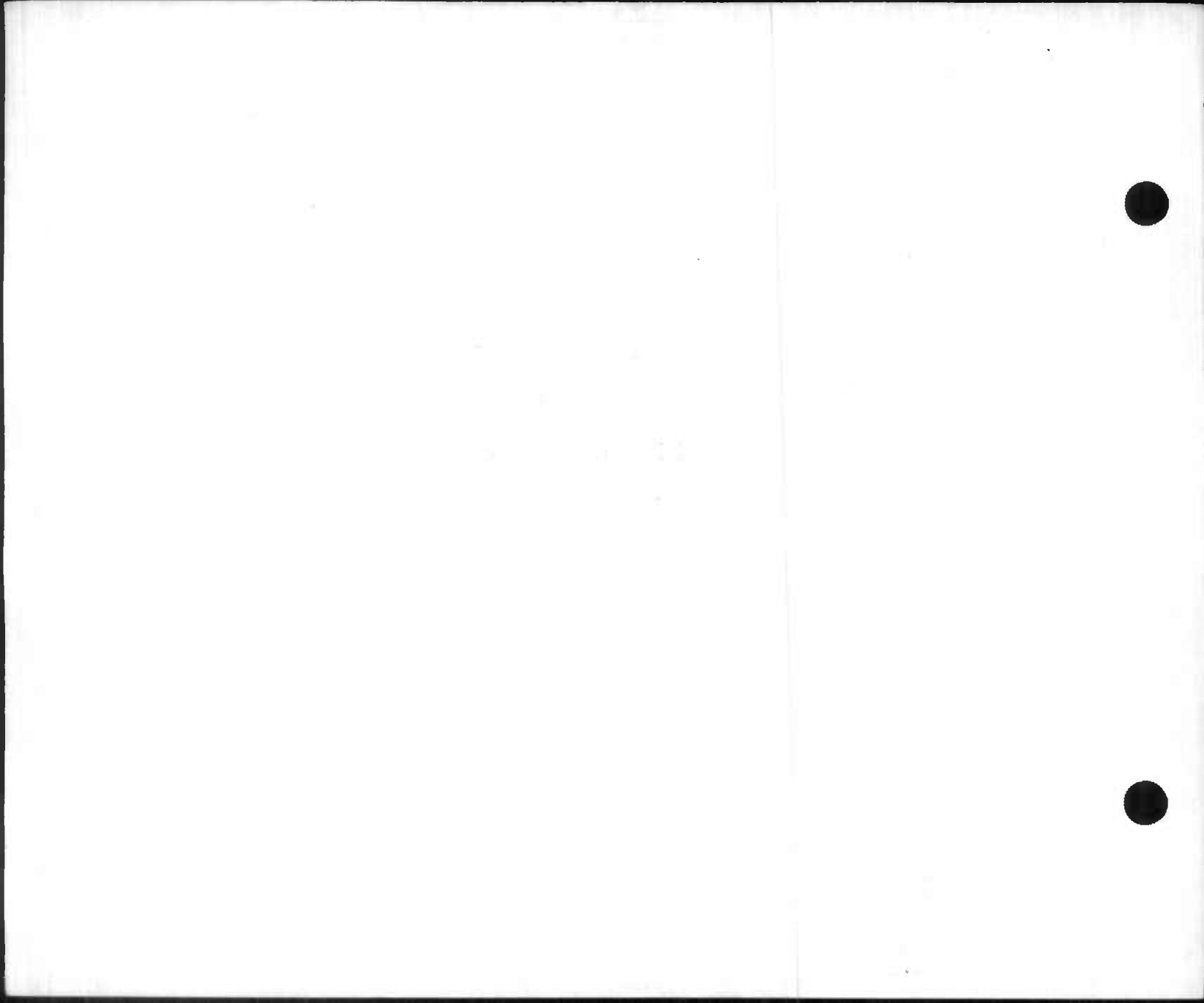
1 - FOR
STATE
REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | | | | | | | | | | | |
|--|--|---|--|--|--|--|--|---|--|--|--|---|--|--|--|---|--|
| 1. DECEASED NAME
(TYPE OR PRINT) | | FIRST | | MIDDLE | | LAST | | 2a. DATE OF DEATH | | MONTH | | DAY | | YEAR | | 2b. HOUR | |
| Robert | | H. | | Horton | | | | 2 | | 3 | | 82 | | | | | |
| 3. SEX | | 4. RACE | | 5. DATE OF BIRTH | | 6. AGE (IN YEARS LAST BIRTHDAY) | | 7. BIRTHPLACE (STATE OR FOREIGN COUNTRY) | | 7b. CITIZEN OF WHAT COUNTRY? | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH | | 10. CITY OR TOWN OF DEATH | |
| Male | | Black | | 8 MONTH DAY 22 YEAR 20 | | 61 | | VA | | USA | | | | Baltimore City | | Baltimore | |
| 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | | 12b. KIND OF BUSINESS OR INDUSTRY | | 13a. STATE | | 13b. COUNTY | | 13c. CITY OR TOWN | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS | | | |
| Provident Hospital | | | | | | MD | | | | Baltimore | | YES | | 2312 Anoka Avenue | | | |
| 14. FATHER'S NAME | | 15. MOTHER'S MAIDEN NAME | | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) | | 16b. SOCIAL SECURITY NO. | | 17. INFORMANT | | ADDRESS | | 18. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| Jesse | | Ethel | | Yes | | 218-03-8728 | | Ella Horton | | 2312 Anoka Avenue | | | | | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | 22a. I certify that (I) (this hospital) attended the deceased from 19_____, to 19_____, that (I) (we) lost saw the deceased alive on above, (I) (we) (did) (did not) view the body after death. | | 22b. SIGNATURE DEGREE | | 22c. DATE SIGNED | |
| | | | | | | | | | | | | Paul Schwartz M.D. | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) | | 23b. DATE | | 23c. NAME OF CEMETERY OR CREMATORY | | 23d. LOCATION CITY OR TOWN COUNTY STATE | | 24. FUNERAL DIRECTOR NAME | | 25a. DATE REC'D BY REGISTRAR | | 25b. REGISTRAR'S SIGNATURE | | 26. DATE OF OPERATION | | 27. CONDITION FOR WHICH OPERATION WAS PERFORMED | |
| Burial | | 2/9/82 | | Md. Veteran Cem | | Crownsville MD | | Wm. C. March F/H 1101 E. North Ave. | | FEB 5 1982 | | Name | | | | | |

DHMH-16 20M
(VRA 15.4) 7/78

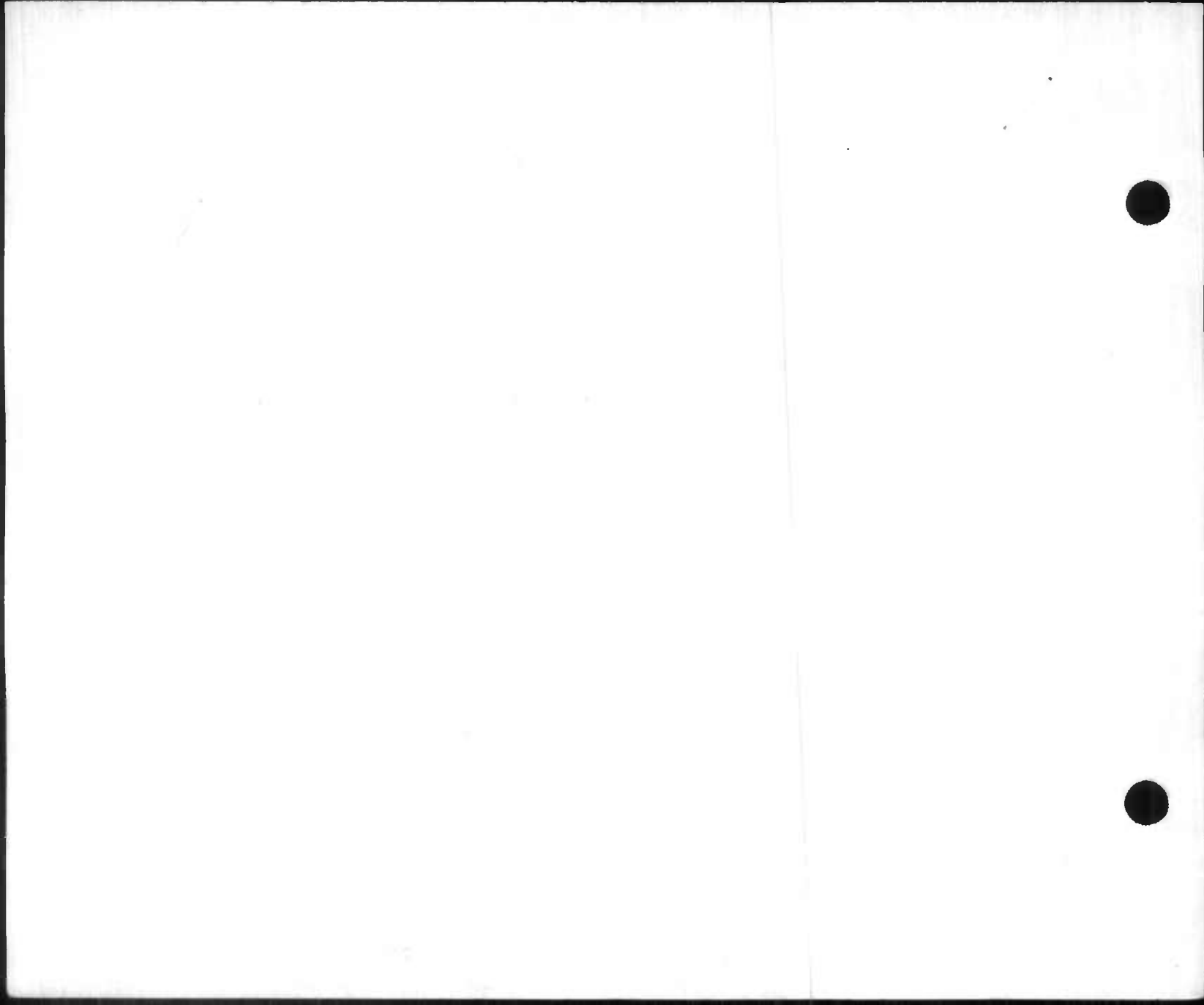


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| STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH | | | | 8 2 0 3 8 5 1 | | | |
|--|--|--|--|---|--|---|--|
| 1. FOR STATE REGISTRAR | | | | REG. NO. | | | |
| 1. DECEASED NAME (TYPE OR PRINT) | | | | 2a. DATE OF DEATH | | 2b. HOUR | |
| FIRST MIDDLE LAST
LEROY HOUCK | | | | MONTH DAY YEAR
2 9 82 | | 7 20P M | |
| 3. SEX | | 4. RACE | | 5. DATE OF BIRTH | | 6. AGE (IN YEARS LAST BIRTHDAY) | |
| M | | White | | MONTH DAY YEAR
10 25 16 | | 65 YRS. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) | | 7b. CITIZEN OF WHAT COUNTRY? | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH | |
| Maryland | | USA | | | | City MD. | |
| 10. CITY OR TOWN OF DEATH | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | | 12b. KIND OF BUSINESS OR INDUSTRY | |
| BALT. | | SINAI HOSPITAL | | Foreman Dover Poultry Products | | | |
| 13a. STATE | | 13b. COUNTY | | 13c. CITY OR TOWN | | 13d. INSIDE CITY LIMITS? | |
| MD | | City | | BALT. | | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 14. FATHER'S NAME | | 15. MOTHER'S MAIDEN NAME | | 13e. STREET ADDRESS | | | |
| FIRST MIDDLE LAST
William HOUCK | | FIRST MIDDLE LAST
Amelia DELL | | 5315 LIBERTY HEIGHTS AVE | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) | | 16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) | | 17. INFORMANT | | | |
| No | | 213-05-8358 | | Mrs. Evelyn Houck 5315 Liberty Heights Ave. Baltimore, Md. 21207 | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) | | | | | | | |
| PART I. DEATH WAS CAUSED BY | | | | | | | |
| IMMEDIATE CAUSE (a) <u>Renal failure, progressive</u> | | | | | | | |
| 1889 DUE TO, OR AS A CONSEQUENCE OF <u>poorly differentiated</u> | | | | | | | |
| (b) <u>adenocarcinoma of the bladder, metastatic</u> | | | | | | | |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last | | | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF <u>CA of the bladder, metastatic</u> | | | | | | | |
| (c) <u>CHF, mild 2° to Anemia 2° to chronic Hemolytic p. bladder.</u> | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) | | | | | | | |
| 19a. DATE OF OPERATION | | | | | | | |
| 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | | | | |
| 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | | | |
| 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | | | | | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | | | | |
| 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR
P.M. 19 | | | | | | | |
| 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | | | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/> | | | | | | | |
| 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | | | | | | |
| 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) lost
saw the deceased alive on _____, 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated
above, (I) (we) (did) (did not) view the body after death. | | | | | | | |
| 22b. SIGNATURE <u>E. L. M.</u> DEGREE | | | | | | | |
| ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> | | | | | | | |
| 22c. DATE SIGNED | | | | | | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) <u>E. L. M. / K. ZONIES, M.D.</u> | | | | | | | |
| 22e. ADDRESS <u>SINAI HOSP., BALTIMORE, MD.</u> | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u> | | | | | | | |
| 23b. DATE <u>2/13/82</u> | | | | | | | |
| 23c. NAME OF CEMETERY OR CREMATORY <u>Loudon Park Cemetery</u> | | | | | | | |
| 23d. LOCATION CITY OR TOWN COUNTY STATE
<u>Baltimore City MD</u> | | | | | | | |
| 24. FUNERAL DIRECTOR NAME <u>Loring Byers Funeral Directors, Inc.</u> | | | | | | | |
| 25a. DATE REC'D. BY REGISTRAR <u>FEB 11 1982</u> | | | | | | | |
| 25b. REGISTRAR'S SIGNATURE <u>James J. Martin</u> | | | | | | | |
| 25c. ADDRESS <u>8728 Liberty Road Randallstown, MD. 21133</u> | | | | | | | |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 of 2 should be retained by the hospital or attending physician.

DHMH - 16 50M 1/81
(VRA 15, 4)TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.FOR
1 - STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | |
|---|--|--|---|---|-----------------------------|--|--|
| 1. DECEASED NAME
(TYPE OR PRINT)
FIRST MIDDLE LAST
TEDDIE R. HOVATTER | | | 2a. DATE OF DEATH
MONTH DAY YEAR
2/21/82 | | 2b. HOUR
730 A.M. | | |
| 3. SEX
Male | | 4. RACE
White | | 5. DATE OF BIRTH
MONTH DAY YEAR
Feb. 24, 1902 | | 6. AGE (IN YEARS LAST BIRTHDAY)
79 YRS | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
W. Va. | | 7b. CITIZEN OF WHAT COUNTRY?
USA | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
Baltimore City MD. | |
| 10. CITY OR TOWN OF DEATH
Baltimore | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
Baltimore City Hospitals | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
Retired | | 12b. KIND OF BUSINESS OR INDUSTRY
B&O RR | |
| 13a. STATE
Maryland | | 13b. COUNTY | | 13c. CITY OR TOWN
Baltimore | | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 13e. STREET ADDRESS
438 Cornwall Street | | 14. FATHER'S NAME
FIRST MIDDLE LAST
? Hovatter | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
Maude Kines | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)
No | | 16b. SOCIAL SECURITY NO. | | 17. INFORMANT
ADDRESS
Donald G. Ford, Grafton, W. Va. | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART 1. DEATH WAS CAUSED BY:
4100 IMMEDIATE CAUSE (a) Cardio Respiratory Arrest
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last:
(b) Myocardial infarct
DUE TO, OR AS A CONSEQUENCE OF
(c) | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: 0 | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK AT WORK | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | |
| 22a. I certify that (I) (his hospital) attended the deceased from 2/18 19 82 , to 2/21 19 82 , that (I/we) last saw the deceased alive on 2/21/82 , and that in (my/our) opinion death occurred on the date and hour and from the causes stated above. (I/we) did not view the body after death. | | | | | | | |
| 22b. SIGNATURE
M. Stracke MD | | | | DEGREE | | 22c. DATE SIGNED
2/21/82 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
M. STRACKE | | | | 22e. ADDRESS
Balto 213 Hop | | | |
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)
Removal | | 23b. DATE
2/26/82 | | 23c. NAME OF CEMETERY OR CREMATORY
Locust Grove | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
Barbour Co., W. VA. | |
| 24. FUNERAL DIRECTOR
NAME
Henry W. Jenkins & Sons Co.
ADDRESS
4905 York Road Balto., Md. 21212 | | | | 25a. DATE REC'D BY REGISTRAR
FEB 22 1982
REGISTRAR'S SIGNATURE
James J. [Signature] | | | |

MEDICAL CERTIFICATION

29

2605 BP

1985 12 23



FOR
STATE
REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

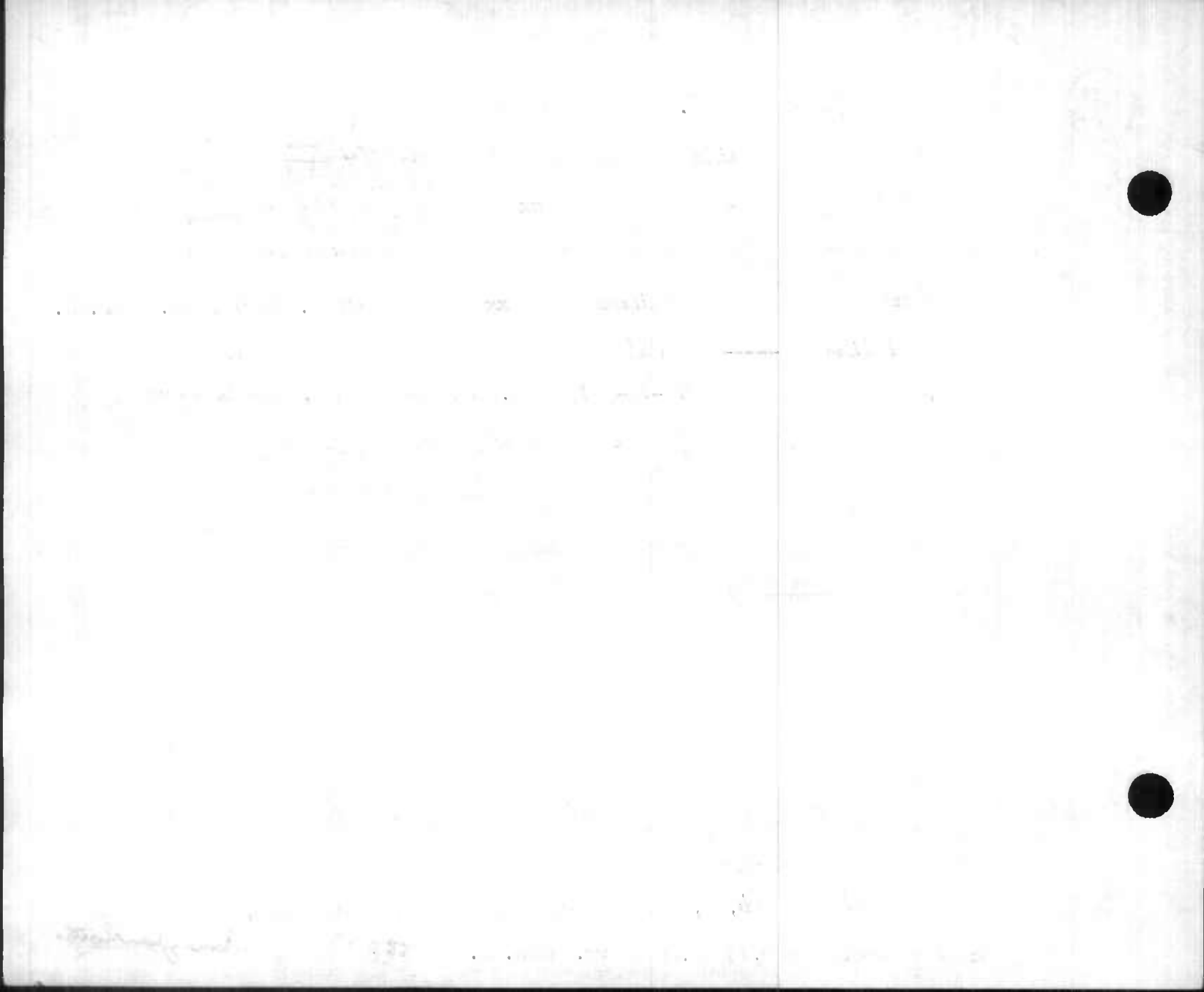
REG. NO.

8 2 0 3 8 5 3

| | | | | | | | | | | |
|--|--|---|--|---|--|---|---|--|---|--|
| 1. DECEASED NAME
(TYPE OR PRINT)
Clara C. Hubbard | | | 2a. DATE OF DEATH
MONTH DAY YEAR
2 12 82 | | | 2b. HOUR
8:05 A.M. | | | | |
| 3. SEX
Female | | 4. RACE
White | | 5. DATE OF BIRTH
MONTH DAY YEAR
1 9 08 | | 6. AGE (IN YEARS LAST BIRTHDAY)
74 YRS. | | IF UNDER 1 YEAR
MONTHS DAYS
IF UNDER 24 HRS.
HOURS MIN. | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
Md. | | 7b. CITIZEN OF WHAT COUNTRY?
USA | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
Balto. City MD. | | | | |
| 10. CITY OR TOWN OF DEATH
Baltimore | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
Bon Secours Hospital | | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
Housewife | | 12b. KIND OF BUSINESS OR INDUSTRY | | | |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)
13a. STATE
Maryland | | | | | 13b. COUNTY
Baltimore | | 13c. CITY OR TOWN
Baltimore | | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
William ----- Ohl | | | | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
Unknown | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
No | | | 16b. SOCIAL SECURITY NO.
(IF YES, GIVE WAR OR DATES)
219-10-9039 | | 17. INFORMANT
Mr. Paul Leo Hubbard, Same as above | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:
4100 IMMEDIATE CAUSE (a) Myocardial Infarction
DUE TO, OR AS A CONSEQUENCE OF
(b) Coronary Arteriosclerosis
DUE TO, OR AS A CONSEQUENCE OF
(c)
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a):
Dehydration | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER NOTIFY MEDICAL EXAMINER) | | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | | | |
| 21d. INJURY OCCURRED
WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 2-1-82 to 2-12-82, that (I) (we) last saw the deceased alive on 2-11-82, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) did (did not) view the body after death. | | | | | | | | | | |
| 22b. SIGNATURE
M.D. | | | | | DEGREE
M.D. | | | 22c. DATE SIGNED | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
M. K. HANON | | | | | 22e. ADDRESS
2717 - Hammond Ferry Rd 21227 | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)
Burial | | | 23b. DATE
Feb, 15, 1982 | | 23c. NAME OF CEMETERY OR CREMATORY
Loudon Park Cemetery | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
Baltimore, Maryland | | | |
| 24. FUNERAL DIRECTOR
NAME
McCutty Funeral Home, 130 E. Fort Ave. Balto. Md. | | | | | 25a. DATE REC'D. BY REGISTRAR
FEB 16 1982 | | 25b. REGISTRAR'S SIGNATURE
Thomas J. [Signature] | | | |

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 returned by the hospital or attending physician.



STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 2 0 3 8 5 4

FOR
1- STATE
REGISTRAR

REG. NO.

| | | | | | | | | | | |
|---|--|--|---|--|---|---|---|--|--|--|
| 1. DECEASED NAME
(TYPE OR PRINT)
LILLIAN HUETHER | | | 2a. DATE OF DEATH
MONTH DAY YEAR
FEBRUARY 19, 1982 | | | 2b. HOUR
11:00AM | | | | |
| 3. SEX
FEMALE | | 4. RACE
CAUCASIAN | | 5. DATE OF BIRTH
MONTH DAY YEAR
09 14 02 | | 6. AGE (IN YEARS LAST BIRTHDAY)
79 YRS. | | IF UNDER 1 YEAR
MONTHS DAYS HOURS MIN.
IF UNDER 24 HRS. | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
MARYLAND | | 7b. CITIZEN OF WHAT COUNTRY?
USA | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
BALTIMORE CITY MD. | | | | |
| 10. CITY OR TOWN OF DEATH
BALTIMORE | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
THE JOHNS HOPKINS HOSPITAL | | | | 12a. USUAL OCCUPATION
(TYPE OF WORK, BUSINESS, OR WORKING LIFE)
DISABLED | | 12b. KIND OF BUSINESS OR INDUSTRY
---- | | |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)
MARYLAND | | | 13b. COUNTY
BALTIMORE | | 13c. CITY OR TOWN
BALTIMORE | | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS
811 N. CHESTER ST. | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
DANIEL HUETHER | | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
MINNIE PETERSON | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
NO | | | 16b. SOCIAL SECURITY NO.
212034686 | | 17. INFORMANT
ADDRESS
DORIS KEDZIERSKI 130 N. ELLWOOD AVE. | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Cardiomyopathy arrest
4275
DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost
(b) Respiratory failure
DUE TO, OR AS A CONSEQUENCE OF
(c) Idiopathic myocardial infarction | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
10 minutes
24 hours | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: (a)
Idiopathic myocardial infarction | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2) | | | | |
| 21d. INJURY OCCURRED
WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 2/17 , 19 82 , to 2/19 , 19 82 , that (I) (we) lost
saw the deceased alive on 2/19 , 19 82 , and that in my (our) opinion death occurred on the date and hour and from the causes stated
above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | | |
| 22b. SIGNATURE
H. Siebens | | | | | | DEGREE
MD | | 22c. DATE SIGNED
2/19/82 | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
HILARY SIEBENS | | | | | | 22e. ADDRESS
JOHNS HOPKINS HOSPITAL, BALTIMORE | | | | |
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)
BURIAL | | | 23b. DATE
2/22/82 | | 23c. NAME OF CEMETERY OR CREMATORY
MT. CARMEL | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
BALTO. BALTO. MD. | | | |
| 24. FUNERAL DIRECTOR
Jeff Coach | | | | | | 25a. DATE REC'D. BY REGISTRAR
FEB 22 1982 | | 25b. REGISTRAR'S SIGNATURE
James J. K. K... | | |

50

120-03-11

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 2 0 3 8 5 5

FOR
 1. STATE
 REGISTRAR

REG. NO.

| | | | | | |
|--|---|---|---|--|--|
| 1. DECEASED NAME
(TYPE OR PRINT)
Oscar T Hughes | | | 2a. DATE OF DEATH
MONTH DAY YEAR
2/18/82 | | 2b. HOUR
5:32 P.M. |
| 3. SEX
Male | 4. RACE
White | 5. DATE OF BIRTH
MONTH DAY YEAR
1/24/09 | 6. AGE (IN YEARS LAST BIRTHDAY)
73 | 7. UNDER 1 YEAR
MONTHS DAYS HOURS MIN. | |
| 7. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
Pennsylvania | 7b. CITIZEN OF WHAT COUNTRY?
USA | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 9. BALTIMORE CITY OR COUNTY OF DEATH
Baltimore City MD. | | |
| 10. CITY OR TOWN OF DEATH
Baltimore | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
Baltimore City Hospitals | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
Electrician | 12b. KIND OF BUSINESS OR INDUSTRY
Beth. Steel | |
| 13a. STATE
Maryland | | | 13b. COUNTY
Baltimore | 13c. CITY OR TOWN
Dundalk | 13d. INSIDE CITY LIMITS?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
Thomas H. Hughes | | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
Cora L. Fox | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
Yes | | 16b. SOCIAL SECURITY NO.
(IF YES, GIVE WAR OR DATES)
WW II | 17. INFORMANT
Elinor L. Hughes | ADDRESS
6 Graywood Road Balto., MD. 21222 | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>cardiopulmonary arrest</u>
<u>4280</u>
DUE TO, OR AS A CONSEQUENCE OF
(b) <u>congestive heart failure</u>
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(c) _____
DUE TO, OR AS A CONSEQUENCE OF
(c) _____ | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK AT WORK | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>2/18</u> , 19 <u>82</u> , to <u>2/18</u> , 19 <u>82</u> , that (I) (we) last saw the deceased alive on <u>2/18</u> , 19 <u>82</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | |
| 22b. SIGNATURE
Mark C. Liu | | DEGREE
M.D. | | 22c. DATE SIGNED
2/18/82 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
Liu | | 22e. ADDRESS
Baltimore City Hosp. | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)
Burial | 23b. DATE
2/22/1982 | 23c. NAME OF CEMETERY OR CREMATORY
Meadowridge | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
Dorsey Maryland | |
| 24. FUNERAL DIRECTOR
NAME
Duda-Ruck, Inc.
7922 Wise Avenue Dundalk, MD. 21222 | | | 25a. DATE REC'D. BY REGISTRAR
FEB 22 1982 | | |
| | | | 25b. REGISTRAR'S SIGNATURE
Charles J. Nathan | | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner(s) be notified at once.

1. The first part of the report is a summary of the work done during the period covered by the report. It includes a brief description of the objectives of the work, the methods used, and the results obtained.

2. The second part of the report is a detailed description of the work done during the period covered by the report. It includes a description of the objectives of the work, the methods used, and the results obtained.

3. The third part of the report is a discussion of the results obtained during the period covered by the report. It includes a discussion of the significance of the results, the limitations of the study, and the conclusions drawn from the study.

4. The fourth part of the report is a conclusion. It includes a summary of the main findings of the study and a statement of the author's conclusions.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at 1607 BP1 - FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | |
|--|--|---|---|--|---|
| 1. DECEASED NAME
(TYPE OR PRINT)
M. ELIZABETH HUGHLETT | | | 2a. DATE OF DEATH
MONTH DAY YEAR
2 2 82 | | 2b. HOUR
5:03 A.M. |
| 3. SEX
Female | 4. RACE
White | 5. DATE OF BIRTH
MONTH DAY YEAR
Jan. 21, 1895 | 6. AGE (IN YEARS LAST BIRTHDAY)
87 YRS | | IF UNDER 1 YEAR
MONTHS DAYS
IF UNDER 24 HRS
HOURS MIN. |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
Maryland | 7b. CITIZEN OF WHAT COUNTRY?
USA | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 9. BALTIMORE CITY OR COUNTY OF DEATH
Baltimore City MD. | | |
| 10. CITY OR TOWN OF DEATH
Baltimore | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
Lutheran Hospital | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
Homemaker | | 12b. KIND OF BUSINESS OR INDUSTRY
Own Home |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)
13a. STATE Maryland 13b. COUNTY 13c. CITY OR TOWN Baltimore 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> 13e. STREET ADDRESS 3301 Poplar Street | | | | | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
Fred Troeger | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
Alice Bauer | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
No | | 16b. SOCIAL SECURITY NO.
036 16 1914 | | 17. INFORMANT ADDRESS
Mrs. Alice Traficante, Balto., Md. | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) 4860 CARDIOPULMONARY ARREST
DUE TO, OR AS A CONSEQUENCE OF (b) PNEUMONIA
DUE TO, OR AS A CONSEQUENCE OF (c)
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| MEDICAL CERTIFICATION | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) | |
| 21d. INJURY OCCURRED
WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | |
| 22a. I certify that (I) (this hospital) attended the deceased from JAN 30, 19 82, to FEB 2, 19 82, that (I) (we) last saw the deceased alive on FEB 2, 19 82, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death. | | | | | |
| 22b. SIGNATURE
John H. Weigel MD | | DEGREE
AD. | | 22c. DATE SIGNED
2-2-82 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
JOHN H. WEIGEL MD | | 22e. ADDRESS
LUTHERAN HOSPITAL | | | |
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)
Burial | | 23b. DATE
2/5/82 | | 23c. NAME OF CEMETERY OR CREMATORY
Meadowridge | |
| 23d. LOCATION
CITY OR TOWN COUNTY STATE
Balto. Co., Md. | | 23e. DATE REC'D. BY REGISTRAR
FEB 4 1982 | | 23f. REGISTRAR'S SIGNATURE
Thomas J. [Signature] | |
| 24. FUNERAL DIRECTOR NAME
Henry W. Jenkins & Sons Co.
4905 York Road Balto., Md. 21212 | | | | | |



FEB

U.S. DEPARTMENT OF AGRICULTURE
WASHINGTON, D.C.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified and a medical certification must be completed.

BP

DHMH-16 30M 2/80
(VRA 15, 4)

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 2 0 3 8 5 7

REG. NO.

| | | | | | |
|---|--|---|--|---|--|
| 1. FOR
STATE
REGISTRAR | | 2a. DATE OF DEATH MONTH DAY YEAR
2 15 82 | | 2b. HOUR
9:15 P.M. | |
| 1. DECEASED NAME
(TYPE OR PRINT)
Helen Hester Hunt | | 3. SEX
Female | | 4. RACE
White | |
| 5. DATE OF BIRTH MONTH DAY YEAR
5 03 91 | | 6. AGE IN YEARS (LAST BIRTHDAY)
90 | | 7. IF UNDER 1 YEAR MONTHS DAYS
IF UNDER 24 HRS. HOURS MIN. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
North Carolina | | 7b. CITIZEN OF WHAT COUNTRY?
USA | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | |
| 9. BALTIMORE CITY OR COUNTY OF DEATH
Balti City MD. | | 10. CITY OR TOWN OF DEATH
Baltimore | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
Luthern Hosp of Md. | |
| 12a. USUAL OCCUPATION
(TYPE OF WORK FOR WHICH HE WAS WORKING)
Home Maker | | 12b. KIND OF BUSINESS OR INDUSTRY | | 13a. STREET ADDRESS
118 Rosecrest Dr | |
| 13b. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13c. STREET ADDRESS | | 14. FATHER'S NAME FIRST MIDDLE LAST
William Turnbill | |
| 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST
Unknown | | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN) YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 16b. SOCIAL SECURITY NO.
237-34-2004 | |
| 17. INFORMANT ADDRESS
Taws N H - 455-7693 | | 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART 1. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Sepsis
4860
DUE TO, OR AS A CONSEQUENCE OF
(b) pneumonia and
DUE TO, OR AS A CONSEQUENCE OF
(c) urinary tract infection | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
2 weeks
2 weeks
2 weeks | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)
Serious Disorder | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | | 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR
P.M. 19 | |
| 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1B, PART 1 OR PART 2) | | 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | |
| 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | 22a. I certify that (I) (this hospital) attended the deceased from 2/2, 19 82, to 2/15, 19 82, that (I) (we) last saw the deceased alive on 2/15, 19 82, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | |
| 22b. SIGNATURE
J. Jakobovits | | DEGREE
MD | | 22c. DATE SIGNED
2/15/82 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
J. JAKOBOVITS | | 22e. ADDRESS
LUTHERAN Hospital, Balto Md 21208 | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)
Cremation | | 23b. DATE
2/26/82 | | 23c. NAME OF CEMETERY OR CREMATORY
Greenmount | |
| 23d. LOCATION CITY OR TOWN COUNTY STATE
Baltimore, Maryland | | 24. FUNERAL DIRECTOR NAME
Leonard J Ruck Inc. | | 25a. DATE REC'D. BY REGISTRAR
FEB 26 1982 | |
| 25b. REGISTRAR'S SIGNATURE
Frances Sant'Antonia | | | | | |

1010-2048

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1010-2048

1010-2048

1010-2048

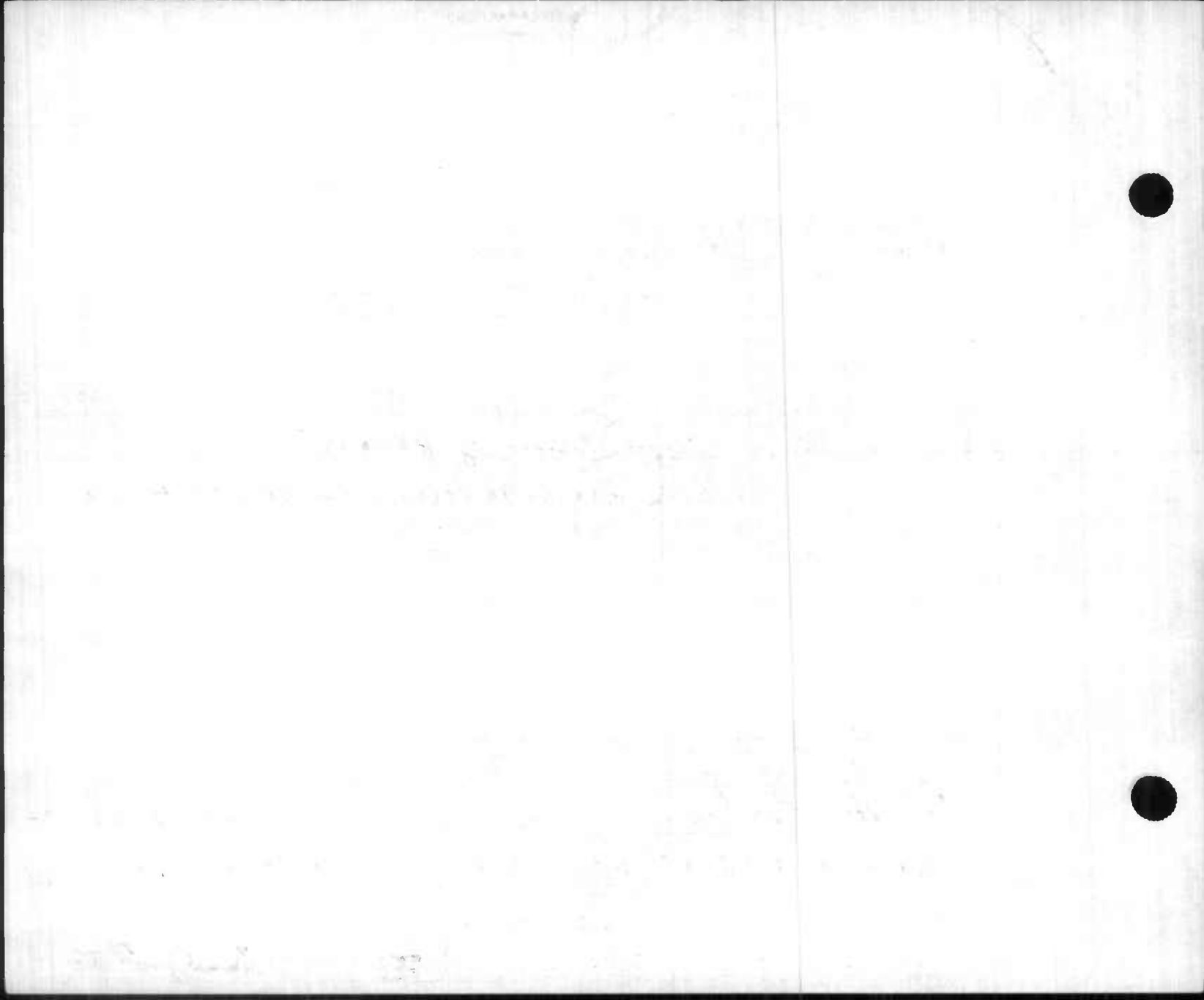
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.FOR
1. STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 2 0 3 8 5 8

REG. NO.

| | | | | | |
|--|---|---|---|--|-----------------------------------|
| 1. DECEASED NAME
(TYPE OR PRINT)
FIRST MIDDLE LAST
Bernice E. Hutchins | | | 2a. DATE OF DEATH
MONTH DAY YEAR
2 20 82 | | 2b. HOUR
M
M |
| 3. SEX
female | 4. RACE
black | 5. DATE OF BIRTH
MONTH DAY YEAR
3 28 1919 | | 6. AGE (IN YEARS LAST BIRTHDAY)
62 YRS. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
Md | 7b. CITIZEN OF WHAT COUNTRY?
USA | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
Baltimore city MD. | |
| 10. CITY OR TOWN OF DEATH
Baltimore | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
1575 Abbottson Street | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE) | | 12b. KIND OF BUSINESS OR INDUSTRY |
| 13a. STATE
Md | 13b. COUNTY | 13c. CITY OR TOWN
Baltimore | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | 13e. STREET ADDRESS
1575 Abbottson Street | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
Samuel Ray | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
Florence Smith | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, GIVE WAR OR DATES)
No | | 16b. SOCIAL SECURITY NO.
N/A | | 17. INFORMANT ADDRESS
Howard Hutchins Jr 6013 High Gate Dr | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART 1. DEATH WAS CAUSED BY:
4140 IMMEDIATE CAUSE (a) Cardio Pulmonary Arrest
DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost:
(b) CORONARY ARTERIO SCLEROTIC HEART DISEASE
DUE TO, OR AS A CONSEQUENCE OF
(c) | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK AT WORK | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | |
| 22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) lost
saw the deceased expire on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated
above. (I) (we) (did not) saw the body after death. | | | | | |
| 22b. SIGNATURE
Walter Burk | | DEGREE
MD | | 22c. DATE SIGNED
2-22-82 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
WALTER BURKES, MD | | 22e. ADDRESS
UNION MEMORIAL Hosp | | | |
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)
Burial | 23b. DATE
2/24/82 | 23c. NAME OF CEMETERY OR CREMATORY
Baltimore Nat Cem | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
Baltimore MD | |
| 24. FUNERAL DIRECTOR
NAME
William C. March | | ADDRESS
F/H 1101 E. North Ave | | 25a. DATE REC'D. BY REGISTRAR
FEB 23 1982 | |
| | | 25b. REGISTRAR'S SIGNATURE
Thomas J. [Signature] | | | |



FOR
1 - STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 2 0 3 8 5 9

REG. NO.

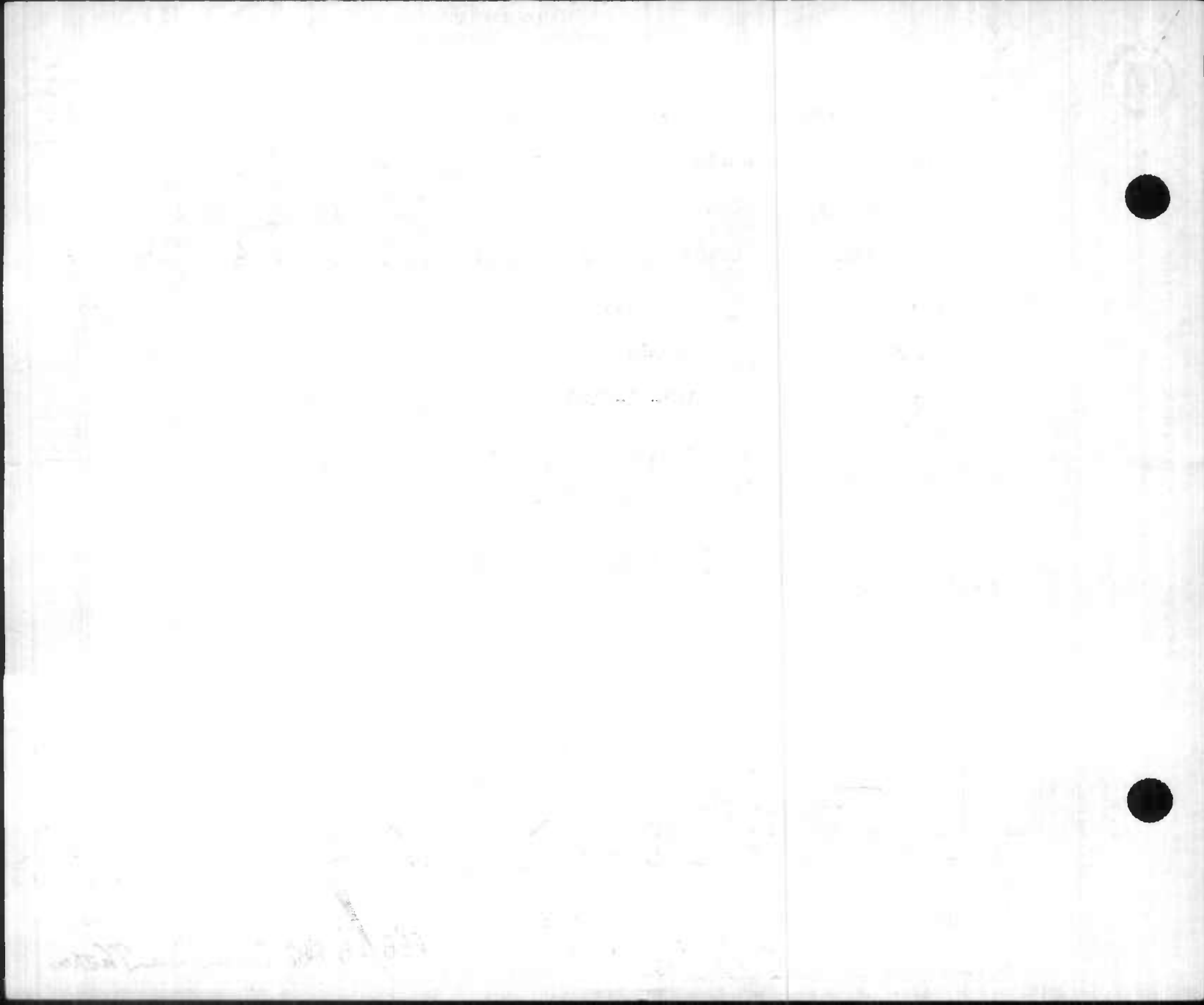
| | | | | | |
|--|--|---|---|--|--|
| 1. DECEASED NAME
(TYPE OR PRINT)
WILLIAM E. HUWALT | | | 2a. DATE OF DEATH
MONTH DAY YEAR
2 11 82 | | 2b. HOUR
9.30 PM |
| 3. SEX
MALE | 4. RACE
WHITE | 5. DATE OF BIRTH
MONTH DAY YEAR
9-26-1910 | | 6. AGE (IN YEARS LAST BIRTHDAY)
71 YRS. | IF UNDER 1 YEAR
MONTHS DAYS
IF UNDER 24 HRS
HOURS MIN. |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
Pennsylvania | 7b. CITIZEN OF WHAT COUNTRY?
USA | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 9. BALTIMORE CITY OR COUNTY OF DEATH
BALTIMORE CITY MD. | | |
| 10. CITY OR TOWN OF DEATH
BALTIMORE | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
UNION MEMORIAL HOSPITAL | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
Maintenance | 12b. KIND OF BUSINESS OR INDUSTRY
College | |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) | | | | | |
| 13a. STATE
MD. | 13b. COUNTY | 13c. CITY OR TOWN
Balto. | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | 13e. STREET ADDRESS
3412 Guilford Terrace | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
Frank HUWALT | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
Mary Steiner | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
No | 16b. SOCIAL SECURITY NO.
(IF YES, GIVE WAR OR DATES)
167-01-9128 | 17. INFORMANT
ADDRESS
Mrs. Dory A. Torres | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART 1: DEATH WAS CAUSED BY
IMMEDIATE CAUSE (a) <u>Acute myocardial infarction</u>
4100
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost
(b) <u>ASEVD</u>
(c) <u>_____</u>
DUE TO, OR AS A CONSEQUENCE OF | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
minutes |
| PART 2: OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <u>COPD</u> | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input type="checkbox"/> | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1B, PART 1 OR PART 2) | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>July</u> 19 <u>76</u> , to <u>Feb. 11</u> 19 <u>82</u> , that (I) (we) last saw the deceased alive on <u>2-4</u> 19 <u>82</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | |
| 22b. SIGNATURE
<u>[Signature]</u> | | DEGREE
ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | 22c. DATE SIGNED
2-13-82 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
Evangelos C. LIGNOS | | 22e. ADDRESS
201 E. University Pkwy, Baltimore MD, 21218 | | | |
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)
CREMATION | 23b. DATE
2-13-1982 | 23c. NAME OF CEMETERY OR CREMATORY
Security Process, Inc. Balto. | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
Md. | |
| 24. FUNERAL DIRECTOR
NAME
MacNabb Funeral Home 301 Frederick Rd. | | 25. DATE PREPARED BY REGISTRAR
FEB 16 1982 | | 25. REGISTRAR'S SIGNATURE
<u>[Signature]</u> | |

The medical examiner must be notified at once.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.



STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 2 0 3 8 6 0

FOR
1 - STATE
REGISTRAR

REG. NO.

| | | | | | | | |
|--|--|--|--|---|--|---|--|
| 1. DECEASED NAME
(TYPE OR PRINT)
ISAAC | | FIRST MIDDLE LAST
HUYARD | | 2a. DATE OF DEATH
MONTH DAY YEAR
FEBRUARY 18, 1982 | | 2b. HOUR
8:25A | |
| 3. SEX
Male | | 4. RACE
White | | 5. DATE OF BIRTH
MONTH DAY YEAR
3 30 39 | | 6. AGE (IN YEARS LAST BIRTHDAY)
42 YRS. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
Pennsylvania | | 7b. CITIZEN OF WHAT COUNTRY?
U.S.A. | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
BALTIMORE CITY MD. | |
| 10. CITY OR TOWN OF DEATH
Baltimore | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
THE JOHNS HOPKINS HOSPITAL | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
Inspector | | 12b. KIND OF BUSINESS OR INDUSTRY
Sperry of New Holland, Pa. | |
| 13a. STATE
Pennsylvania | | 13b. COUNTY
New Holland | | 13c. CITY OR TOWN
New Holland | | 13d. INSIDE CITY LIMITS?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
Isaac Z. Huyard | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
Ada Teachy | | 13e. STREET ADDRESS
Box 129 New Holland, Pa. | | R.D. 1 | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
NO | | 16b. SOCIAL SECURITY NO.
Unavailable | | 17. INFORMANT
ADDRESS
Furman Home of Funerals 59 W. Main St. | | 17540 | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART 1. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) INADEQUATE CARDIAC OUTPUT
5860
DUE TO, OR AS A CONSEQUENCE OF
(b) CARDIAC Arrhythmias
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last
(c) ELECTROLYTE Imbalance, Cor. Arteriosclerosis
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
12 hrs
1 1/2 hrs | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:
Chronic Renal Failure, Diabetes, SP Transplant | | | | | | | |
| 19a. DATE OF OPERATION
2/18 | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED
Renal Failure | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 2/17 19 82 , to 2/18 19 82 , that (I) (we) lost saw the deceased alive on 2/18 19 82 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (If we did not view the body after death.) | | | | | | | |
| 23a. SIGNATURE
R C Church | | DEGREE
MD | | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> | | 22c. DATE SIGNED
2/18/82 | |
| 23b. PHYSICIAN'S NAME (TYPE OR PRINT)
R C Church | | 22e. ADDRESS
Johns Hopkins | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)
Burial | | 23b. DATE
2/21/82 | | 23c. NAME OF CEMETERY OR CREMATORY
Ridgeview Cemetery | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
Locock Township Lancaster Pa. | |
| 24. FUNERAL DIRECTOR
NAME
Furman Home for Funerals 59 W. Main St. 17540 | | | | 25a. DATE REC'D. BY REGISTRAR
FEB 19 1982 | | 25b. REGISTRAR'S SIGNATURE
James Van Notten | |

BP

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 4 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner should be notified.

595 9 1 154

TO HOSPITAL OR ATTENDING PHYSICIAN. The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use on the burial transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours of death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked on item 18, shows any injury, or other traumatic event, the medical examiner must be notified at once.

1. FOR
STATE
REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | |
|--|--|---|---|---|--|
| 1. DECEASED NAME
(TYPE OR PRINT)
FIRST MIDDLE LAST
DORA HYMAN | | | 2a. DATE OF DEATH
MONTH DAY YEAR
FEB. 7 1982 | | 2b. HOUR
8:45 AM |
| 3. SEX
FEMALE | 4. RACE
CAUCASIAN | 5. DATE OF BIRTH
MONTH DAY YEAR
APRIL 11 1960 | | 6. AGE (IN YEARS LAST BIRTHDAY)
81 YRS. | IF UNDER 1 YEAR
MONTHS DAYS
IF UNDER 24 HRS
HOURS MIN |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
RUSSIA | 7b. CITIZEN OF WHAT COUNTRY?
USA | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
BALTIMORE CITY MD. | |
| 10. CITY OR TOWN OF DEATH
BALTIMORE | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
GERIATRIC CENTER
LEVINVALE HEBRON & HOSPITAL | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
SALESPERSON | 12b. KIND OF BUSINESS OR INDUSTRY
RETAIL | |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)
13b. STATE
MARYLAND | | | 13c. CITY OR TOWN
BALTIMORE | 13d. INSIDE/CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
LEON LITTMAN | | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
SARAH LEVINE | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)
NO | | 16b. SOCIAL SECURITY NO.
225-50-7777 | | 17. INFORMANT
ADDRESS
MRS. DOROTHY L. TISCHLER
6526 BLACKHEAD RD., BALTO., MD 21220 | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) SEPTICEMIA
2859
DUE TO, OR AS A CONSEQUENCE OF
(b) GANGRENE, BOTH FEET
DUE TO, OR AS A CONSEQUENCE OF
(c)
APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATH
10 DAYS
2 WKS. | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)
ANEMIA | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> AT WORK
NOT WHILE <input type="checkbox"/> AT WORK | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | |
| 22a. I certify that (s) (this hospital) attended the deceased from MAY 23 1973, to FEB. 7 1982, that (s) (we) last saw the deceased alive on FEB. 7 1982, and that in (s) (our) opinion death occurred on the date and hour and from the causes stated above, (s) (we) (did) (did not) view the body after death. | | | | | |
| 22b. SIGNATURE
E. Leon | | DEGREE
ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> | | 22c. DATE SIGNED
2/7/82 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
ESTRELITA O. KLU MD | | 22e. ADDRESS
GERIATRIC CENTER
LEVINVALE HEBRON & HOSPITAL | | | |
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)
BURIAL | | 23b. DATE
FEB. 8, 1982 | | 23c. NAME OF CEMETERY OR CREMATORY
HAR SINAI BENEVOLENT SOC. ROSEDALE BALTO MD | |
| 24. FUNERAL DIRECTOR
NAME
SOL LEVINSON & BROS., INC. | | 24b. ADDRESS
6010 REISTERSTOWN RD. BALTO., MD 21215 | | 25. DATE REC'D. BY REGISTRAR
FEB 11 1982 | |
| | | | | 26. REGISTRAR'S SIGNATURE
Charles Sant Anthony | |



1965-1966
1965-1966

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours of death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

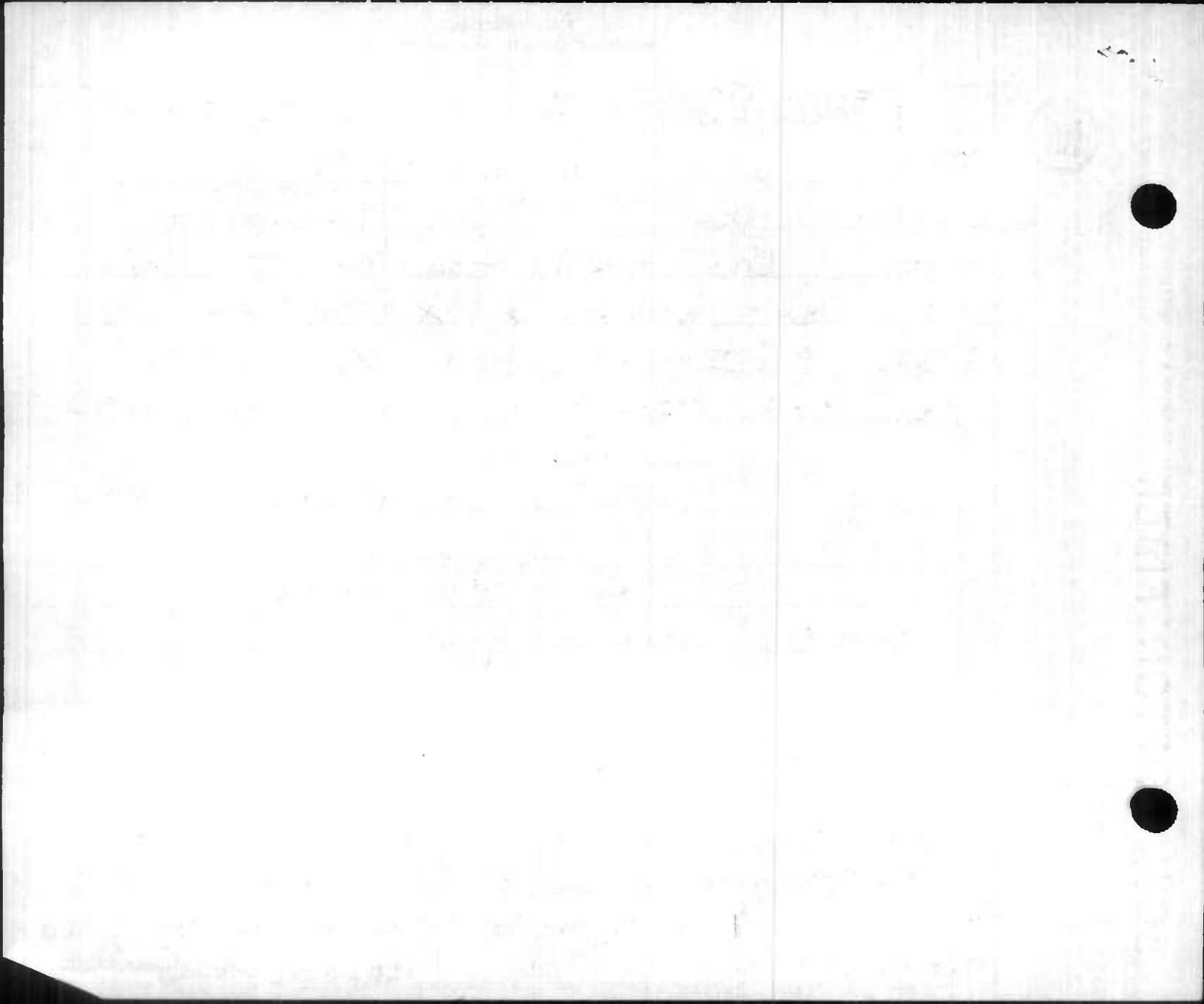
IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

BP

DHMH - 16 50M 1/81
(VRA 15, 4)

| STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH | | | | 8 2 0 3 8 6 2 | | | |
|--|--|---|--|--|--|---|--|
| 1 - FOR STATE REGISTRAR | | | | REG. NO. | | | |
| 1. DECEASED NAME (TYPE OR PRINT) Frank Paul IADORLA, FRANK P. Iadorola | | | | 2a. DATE OF DEATH MONTH DAY YEAR 2:05 PM 2/13/82 | | | |
| 3. SEX male | | 4. RACE white | | 5. DATE OF BIRTH MONTH DAY YEAR May 21 1910 | | 6. AGE (IN YEARS LAST BIRTHDAY) 72 | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) New York | | 7b. CITIZEN OF WHAT COUNTRY? USA | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City MD. | |
| 10. CITY OR TOWN OF DEATH Baltimore | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) University of Md Hosp | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Ret Electric | | 12b. KIND OF BUSINESS OR INDUSTRY Electrician | |
| 13a. RESIDENCE (IF HUSBAND - HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) Mid | | 13b. CITY OR TOWN North Beach | | 13c. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13d. STREET ADDRESS 3947 21st St | |
| 14. FATHER'S NAME FIRST MIDDLE LAST Frank P Iadorola | | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Helen V Henrich | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) Yes | | 16b. SOCIAL SECURITY NO. 42-43 | | 17. INFORMANT ADDRESS Marie V Iadorola same as #B | | | |
| 18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c):
PART 1. DEATH WAS CAUSED BY
IMMEDIATE CAUSE (a) 5374 EXSANGUINATION
DUE TO, OR AS A CONSEQUENCE OF
(b) ABORTO-DUODENAL FISTULA
DUE TO, OR AS A CONSEQUENCE OF
(c) 6 hrs | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: severe coronary artery disease | | | | | | | |
| 19a. DATE OF OPERATION 2-12-82 | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED autoeroded fistula | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 2-11 19 82 to 2-12 19 82 that (I) (we) last saw the deceased alive on 2-12 19 82 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | |
| 22b. SIGNATURE W B Bouche M.D. | | | | DEGREE | | 22c. DATE SIGNED 2-12-82 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) W B Bouche | | | | 22e. ADDRESS 801 Providence Rd. BAY, MD | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | | 23b. DATE 2/15/82 | | 23c. NAME OF CEMETERY OR CREMATORY Southmen Mem Garden | | 23d. LOCATION CITY OR TOWN COUNTY STATE Dunk Colbert Md | |
| 24. FUNERAL DIRECTOR NAME Rausch Funeral Home ADDRESS Owings Md | | | | 25a. DATE REC'D. BY REGISTRAR FEB 18 1982 | | 25b. REGISTRAR'S SIGNATURE [Signature] | |

MEDICAL CERTIFICATION



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours of death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified or a medical certificate filed.

1- FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

8 2 0 3 8 6 3

| | | | | | |
|--|--|---|---|--|--|
| 1. DECEASED NAME
(TYPE OR PRINT) FIRST MIDDLE LAST
SELMA L. IRVIN | | | 2a. DATE OF DEATH MONTH DAY YEAR
2 23 82 | | 2b. HOUR
8:06^{AM} |
| 3. SEX
Female | | 4. RACE
C | 5. DATE OF BIRTH MONTH DAY YEAR
10 13 98 | | 6. AGE (IN YEARS LAST BIRTHDAY) YRS
83 |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
BALTO, Md. | | 7b. CITIZEN OF WHAT COUNTRY?
U.S.A. | | 9. BALTIMORE CITY OR COUNTY OF DEATH
BALTIMORE city MD. | |
| 10. CITY OR TOWN OF DEATH
BALTIMORE | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
South BALTO GEN'L Hosp | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)
house wife | |
| 13a. STATE
Md | | | 13b. CITY OR TOWN
BALTO | | 13c. STREET ADDRESS
3223 EASTERN Ave |
| 14. FATHER'S NAME FIRST MIDDLE LAST
UNK. | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST
UNK. | | |

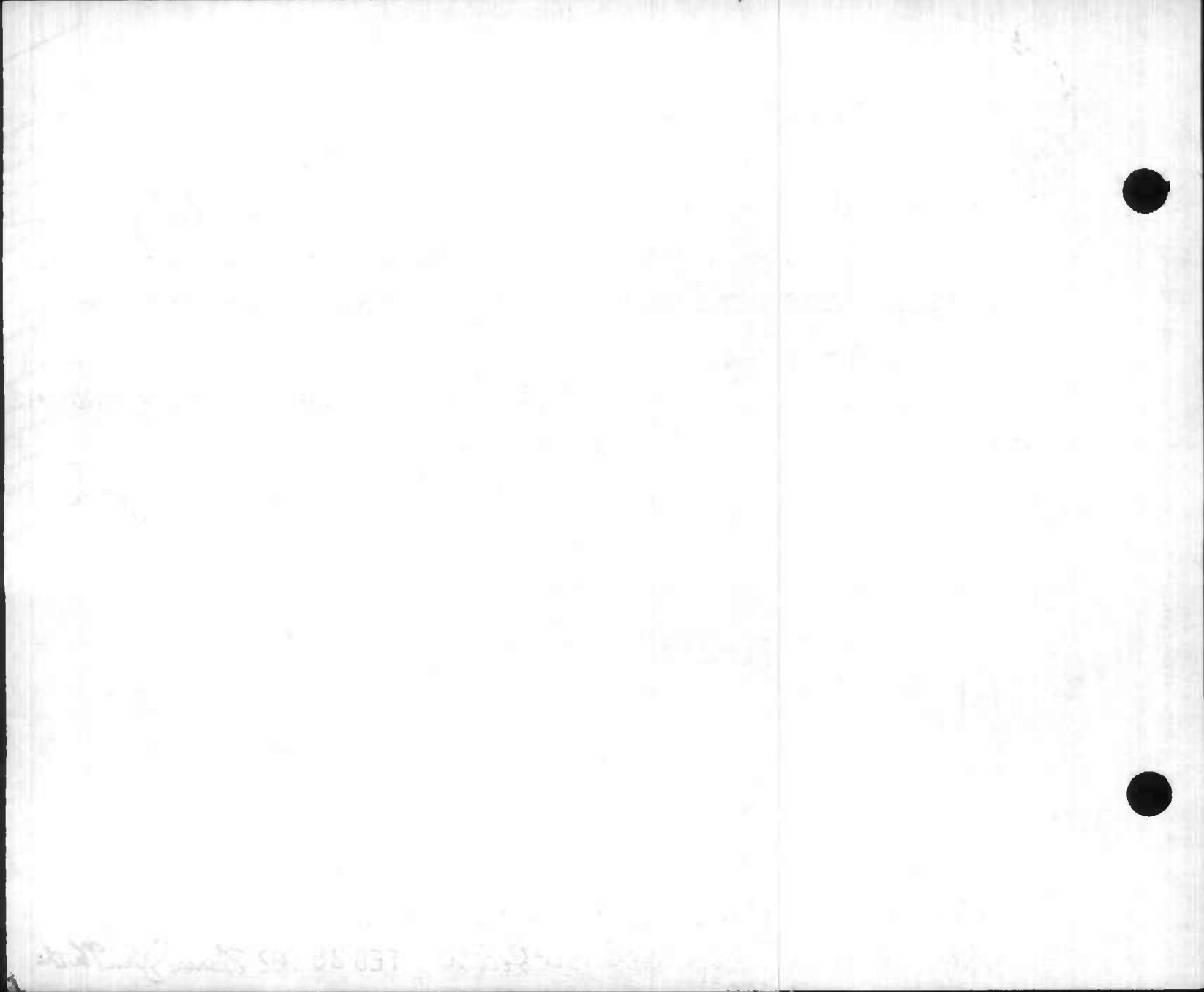
| | | |
|---|--|--|
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES NO OR UNKNOWN)
NO | 16b. SOCIAL SECURITY NO.
212-09-1857 | 17. INFORMANT ADDRESS
Evelyn Bowman 1220 Susquehanna |
|---|--|--|

| | | |
|--|--|--|
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART 1. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Heart Failure
1519
DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b) metastatic Ca (gastric).
DUE TO, OR AS A CONSEQUENCE OF
(c) _____ | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
1 yr. |
|--|--|--|

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: _____

| | | | | | |
|--|--|--|--|---|--|
| 19a. DATE OF OPERATION
_____ | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED
_____ | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
_____ | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR
P.M. 19
_____ | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)
_____ | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK
_____ | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)
_____ | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE
_____ | |
| 22a. I certify that (I) (this hospital) attended the deceased from 2-16 , 19 82 , to 2-23 , 19 82 , that (I) (we) last saw the deceased alive on 2-23 , 19 82 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | |
| 22b. SIGNATURE
Janice I. Masi | | | | 22c. DATE SIGNED
2/23/82 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
Janice I. Masi | | | | 22e. ADDRESS
3001 S. Hanover St. Balto 21230 Md. | |

| | | | |
|---|-----------------------------|--|--|
| 23a. BURIAL, CREMATION, REMOVAL
Burial | 23b. DATE
1-27-82 | 23c. NAME OF CEMETERY OR CREMATORY
Spudis of South | 23d. LOCATION CITY OR COUNTY STATE
BALTO Co. Md. |
| 24. FUNERAL DIRECTOR
Raymond J. Macprowski | | 25. DATE REC'D. BY REGISTRAR
FEB 25 1982 | |
| 26. REGISTRAR'S SIGNATURE
Charles J. Nutter | | 27. REGISTRAR'S SIGNATURE
Charles J. Nutter | |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

Items 13a-13e per phone 3/2/82 d STATE OF MARYLAND

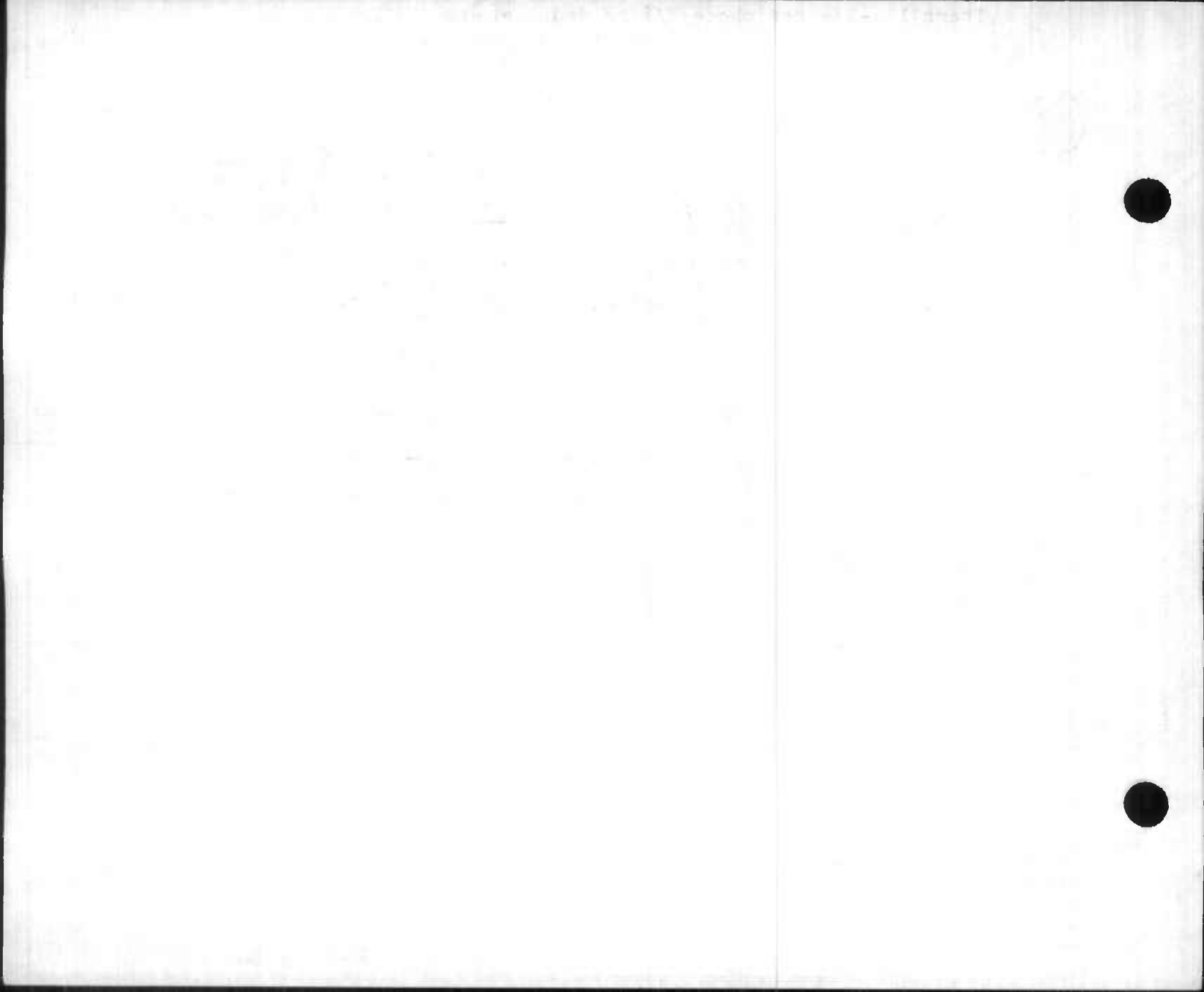
1 - STATE REGISTRAR

DEPARTMENT OF HEALTH AND MENTAL HYGIENE

CERTIFICATE OF DEATH

REG. NO. 8 2 0 3 8 6 4

| | | | | | | | | | |
|--|--|--|-------------------|--|--|--|--|--------------|--|
| 1. DECEASED NAME
(TYPE OR PRINT) | | FIRST | MIDDLE | LAST | 2a. DATE OF DEATH | MONTH | DAY | YEAR | 2b. HOUR |
| Diane | | | | Ithner | 2 | 6 | 82 | | 7:23 A.M. |
| 3. SEX | 4. RACE | 5. DATE OF BIRTH | | | 6. AGE (IN YEARS LAST BIRTHDAY) | | IF UNDER 1 YEAR | | IF UNDER 24 HRS. |
| male | white | MONTH DAY YEAR
1 31 82 | | | 6 days | | MONTHS DAYS | | HOURS MIN. |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) | 7b. CITIZEN OF WHAT COUNTRY? | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | | 9. BALTIMORE CITY OR COUNTY OF DEATH | | | | |
| Maryland | USA | | | | Baltimore City MD. | | | | |
| 10. CITY OR TOWN OF DEATH | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | | 12b. KIND OF BUSINESS OR INDUSTRY | | |
| Baltimore | Baltimore City Hospital | | | | N/A | | | | |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) | | 13b. COUNTY | 13c. CITY OR TOWN | | 13d. INSIDE CITY LIMITS? | | 13e. STREET ADDRESS | | |
| Md. | | | Balto. | | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 1205 Gregor Way 21224 | | |
| 14. FATHER'S NAME | | 15. MOTHER'S MAIDEN NAME | | | | | | | |
| FIRST MIDDLE LAST | | FIRST MIDDLE LAST | | | | | | | |
| | | Ithner | | Diane | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) | | 16b. SOCIAL SECURITY NO. | | 17. INFORMANT ADDRESS | | | | | |
| | | | | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| 5860 IMMEDIATE CAUSE (a) cardiac arrest | | | | | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF (b) renal failure and severe pneumonia | | | | | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF (c) | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (c) | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY? | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? | | |
| | | | | | YES <input type="checkbox"/> NO <input type="checkbox"/> | | YES <input type="checkbox"/> NO <input type="checkbox"/> | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | | | |
| | | HOUR A.M. MONTH DAY YEAR
P.M. 19 | | | | | | | |
| 21d. INJURY OCCURRED | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION | | | | | |
| WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK | | | | STREET CITY OR TOWN COUNTY STATE | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 1-31, 19 82, to 2-6, 19 82, that (I) (we) lost saw the deceased alive on 2-6, 19 82, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | |
| 22b. SIGNATURE | | DEGREE | | | 22c. DATE SIGNED | | | | |
| H. Hwu, M.D. | | | | | 2-6-82 | | | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) | | 22e. ADDRESS | | | ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> | | | | |
| H. Hwu | | Baltimore City Hospital I.C.N. | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) | | 23b. DATE | | 23c. NAME OF CEMETERY OR CREMATORY | | 23d. LOCATION | | COUNTY STATE | |
| | | | | | | CITY OR TOWN | | | |
| 24. FUNERAL DIRECTOR NAME | | | | ADDRESS | | 25a. DATE REC'D. BY REGISTRAR 25b. REGISTRAR'S SIGNATURE | | | |
| | | | | | | FEB 6 1982 | | | |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the registrant, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the records after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

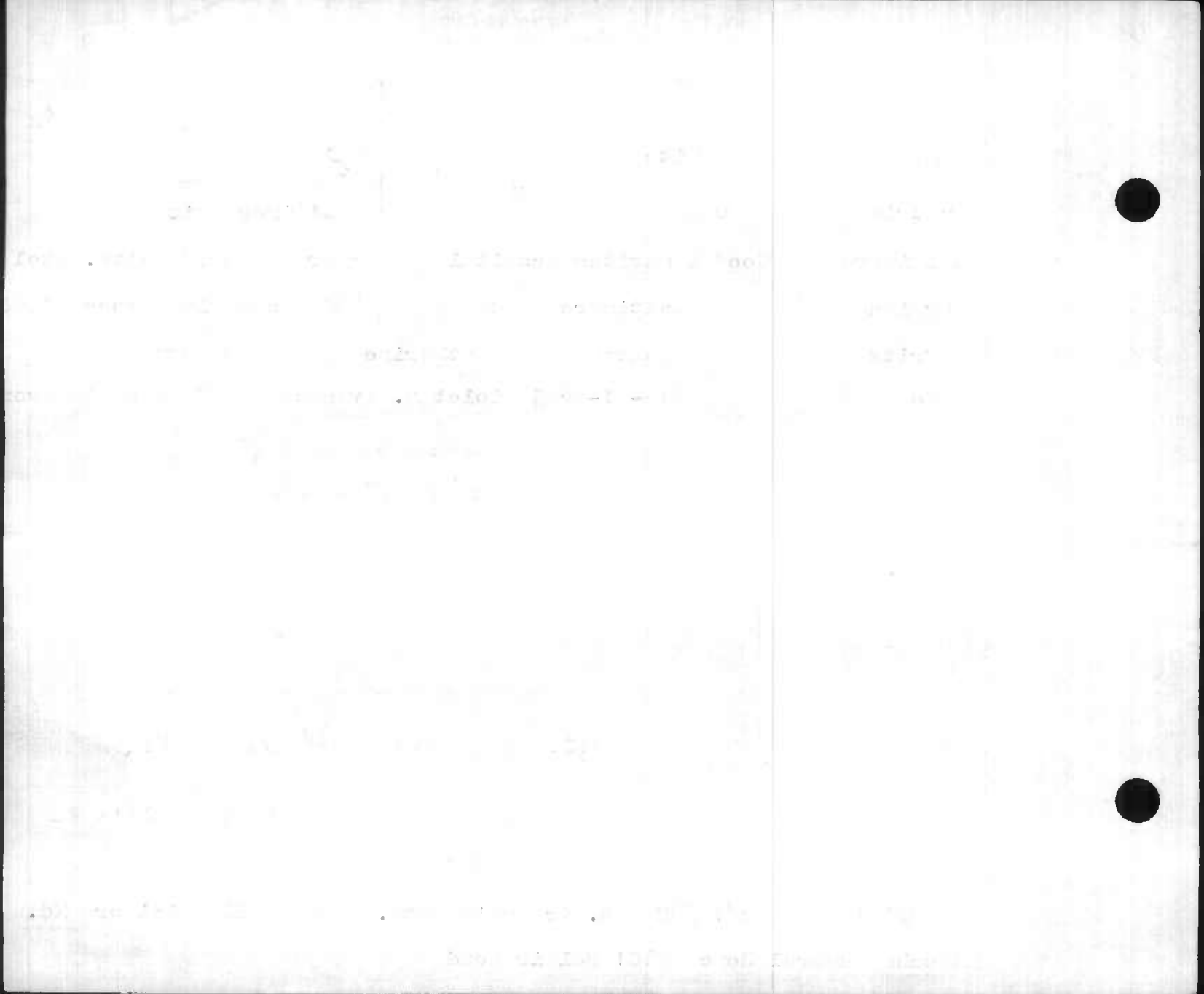
IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1. FOR
STATE
REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | | | |
|--|--|---|---|---|---------------------------------------|--|---|--|--|
| 1. DECEASED NAME
(TYPE OR PRINT) Anton Ivanitch | | | 2a. DATE OF DEATH
MONTH DAY YEAR
2 16 82 | | | 2b. HOUR
12³⁰ A M | | | |
| 3. SEX
male | | 4. RACE
White | | 5. DATE OF BIRTH
MONTH DAY YEAR
6 - 13 - 03 | | 6. AGE (IN YEARS LAST BIRTHDAY)
78 YRS. | | IF UNDER 1 YEAR
MONTHS DAYS
IF UNDER 24 HRS.
HOURS MIN. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
Austria | | 7b. CITIZEN OF WHAT COUNTRY?
USA | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
Baltimore City MD. | | | |
| 10. CITY OR TOWN OF DEATH
Baltimore | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
Good Samaritan Hospital | | | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
Baker | | 12b. KIND OF BUSINESS OR INDUSTRY
Lord Balto. Hotel | |
| 13a. STATE
Maryland | | | 13b. COUNTY | | 13c. CITY OR TOWN
Baltimore | | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
Fritz Ivantch | | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
Katherine Unknown | | | 13e. STREET ADDRESS
4005 Echodale Avenue 21200 | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
No | | 16b. SOCIAL SECURITY NO.
216-01-9695 | | 17. INFORMANT
ADDRESS
Violet M. Ivantch 4005 Echodale Ave | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Cerebro vascular accident
4333
DUE TO, OR AS A CONSEQUENCE OF
(b) Severe bilateral carotid stenosis
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.
DUE TO, OR AS A CONSEQUENCE OF
(c)
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)
Diabetes mellitus | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1b. PART 1 OR PART 2) | | | | | |
| 21d. INJURY OCCURRED
WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from Jan. 28 19 82 , to Feb. 16 19 82 , that (I) (we) lost saw the deceased alive on 2-16 19 82 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | |
| 22b. SIGNATURE
A. S. Cassanego | | | | DEGREE
MD
ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> | | | | 22c. DATE SIGNED
2-16-82 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
A. S. CASSANEGO | | | | 22e. ADDRESS
5601 Loch Raven Blvd. | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)
Burial | | 23b. DATE
2/19/82 | | 23c. NAME OF CEMETERY OR CREMATORY
St. Michael's Luth. | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
Perry Hall Baltimore Md. | | | |
| 24. FUNERAL DIRECTOR
NAME
Lassahn Funeral Home | | | | 25a. DATE REC'D. BY REGISTRAR
FEB 19 1982 | | 25b. REGISTRAR'S SIGNATURE
[Signature] | | | |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please return carbon papers. Pages 1 and 2 should be filed within 72 hours with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified and a post-mortem examination must be performed.

| STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH | | | | REG. NO. | |
|--|-------------------------|---|--|--|--|
| 1. FOR STATE REGISTRAR David Ivins | | | | | |
| 1. DECEASED NAME (TYPE OR PRINT)
FIRST MIDDLE LAST
DAVID SAMUEL IVINS | | | 2a. DATE OF DEATH MONTH DAY YEAR
2/17/82 | | 2b. HOUR
14 M |
| 3. SEX
MALE | 4. RACE
WHITE | 5. DATE OF BIRTH MONTH DAY YEAR
10 11 05 | 6. AGE (IN YEARS LAST BIRTHDAY)
76 YRS | | 7. UNDER 1 YEAR IF UNDER 24 HRS. MONTHS DAYS HOURS MIN. |
| 8. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
MARYLAND | | 7b. CITIZEN OF WHAT COUNTRY?
U.S.A. | 9. BALTIMORE CITY OR COUNTY OF DEATH
BALTIMORE CITY MD | | |
| 10. CITY OR TOWN OF DEATH
BALTIMORE | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
ST. AGNES HOSPITAL | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)
WELDER | | 12b. KIND OF BUSINESS OR INDUSTRY
GENERAL MOTORS |
| 13a. STATE
MARYLAND | | 13b. COUNTY
BALTIMORE | 13c. CITY OR TOWN
CATONSVILLE | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 14. FATHER'S NAME FIRST MIDDLE LAST
HARRY IVINS | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST
HENRIETTA CARTER | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)
NO | | 16b. SOCIAL SECURITY NO.
216-09-8628 | | 17. INFORMANT ADDRESS
MILTON, DELAWARE R.D. 1 Box 285 19968 | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART 1. DEATH WAS CAUSED BY:
4049 IMMEDIATE CAUSE (a) End Stage Renal Disease
DUE TO, OR AS A CONSEQUENCE OF (b) Hypertensive Arteriosclerotic Disease
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.
DUE TO, OR AS A CONSEQUENCE OF (c)
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1. | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | | | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR
19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | |
| 22a. I certify that (I) (this hospital) attended the deceased from 1-23 , 19 82 , to 2-17 , 19 82 , that (I) (we) lost saw the deceased alive on 2-16 , 19 82 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did not) view the body after death. | | | | | |
| 22b. SIGNATURE
Lawrence A. Zeidman | | DEGREE
MD | | 22c. DATE SIGNED
2-17-82 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
Lawrence Zeidman | | 22e. ADDRESS
ST AGNES HOSP 900 S CATON AVE BALTIMORE MD 21229 | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)
BURIAL | | 23b. DATE
02-20-82 | | 23c. NAME OF CEMETERY OR CREMATORY
MEADOWRIDGE MEM. PK. | |
| 23d. LOCATION CITY OR TOWN COUNTY STATE
ELKCRIDGE HOWARD MARYLAND | | | | | |
| 24. FUNERAL DIRECTOR NAME
HUBBARD FUNERAL HOME, INC. | | ADDRESS
4107 WILKENS AVE. | | 25a. DATE REC'D. BY REGISTRAR
FEB 19 1982 | |
| 25b. REGISTRAR'S SIGNATURE
James Van Natten | | | | | |

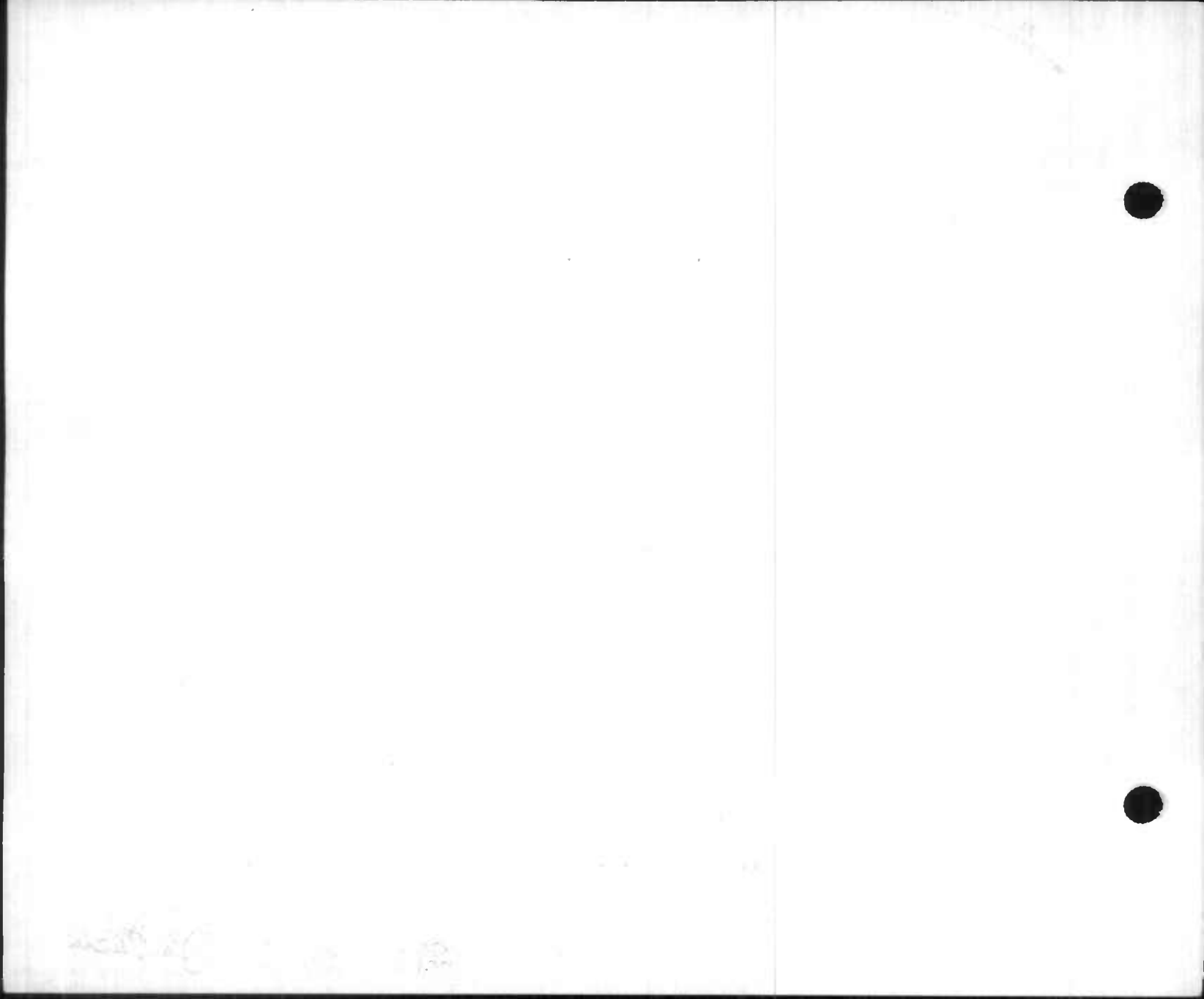
84125170 X 22 P22J33



833 01 837

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, RELEASE EXCISE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 1b. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 24 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

| STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH | | | | | | | | | | REG. NO. 03867 | |
|--|--|--|--|--|--|--|--|--|--|---|--|
| 1- STATE REGISTRAR | | | | | | | | | | 7a. DATE KNOWN OF DEATH | |
| 1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST
BENJAMIN F. JACKSON | | | | | | | | | | MONTH DAY YEAR
2 6 1982 | |
| 2. SEX 4. RACE 5. DATE OF BIRTH (MONTH DAY YEAR) 6. AGE (IN YEARS) (MONTHS DAYS HOURS MIN) | | | | | | | | | | 7b. HOUR
M | |
| male negro 5 9 27 54 YRS. | | | | | | | | | | 2c. DATE PRONOUNCED DEAD
2 6 1982 1p M | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MD 7b. CITIZEN OF WHAT COUNTRY? USA 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | | | | | | | | | 9. BALTIMORE CITY OR COUNTY OF DEATH
Baltimore City MD | |
| 10. CITY OR TOWN OF DEATH Baltimore 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
1606 E. Oliver St. | | | | | | | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | |
| 13a. STATE MD 13b. COUNTY 13c. CITY OR TOWN Baltimore 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> 13e. STREET ADDRESS
1516 N. Payson St. | | | | | | | | | | 12b. KIND OF BUSINESS OR INDUSTRY | |
| 14. FATHER'S NAME FIRST MIDDLE LAST Robert Jackson 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Carrie Garrett | | | | | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) (IF YES, GIVE WAR OR DATES) No 16b. SOCIAL SECURITY NO. 216-30-6328 17. INFORMANT ADDRESS
Mildred Ruffin 1516 N. Payson St. | | | | | | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Congestive heart failure
4280
Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause lost.
(b)
(c) | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a). | | | | | | | | | | | |
| 19a. DATE OF OPERATION 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? 20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | | | | | | | |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) | | | | | | | | | | | |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | | | | | | | | | |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> | | | | | | | | | | | |
| ACTUAL SIGNATURE M.D. Assistant MEDICAL EXAMINER DATE SIGNED 2-7-82 | | | | | | | | | | | |
| EXAMINER'S NAME (TYPE OR PRINT) Ann M. Dixon, M.D. ADDRESS 111 Penn St. | | | | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial 23b. DATE 2/10/82 23c. NAME OF CEMETERY OR CREMATORY Mt. Auburn Cem. 23d. LOCATION CITY OR TOWN COUNTY STATE
Baltimore MD | | | | | | | | | | | |
| 24. FUNERAL DIRECTOR NAME ADDRESS Wm. C. March F/H 1101 E. North Ave. 25a. DATE REC'D. BY REGISTRAR FEB 8 1982 25b. REGISTRAR'S SIGNATURE | | | | | | | | | | | |



TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, REAS-
EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR.
PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES.
TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS
AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET,
BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

Item 236 G 564 2/17/82 GB

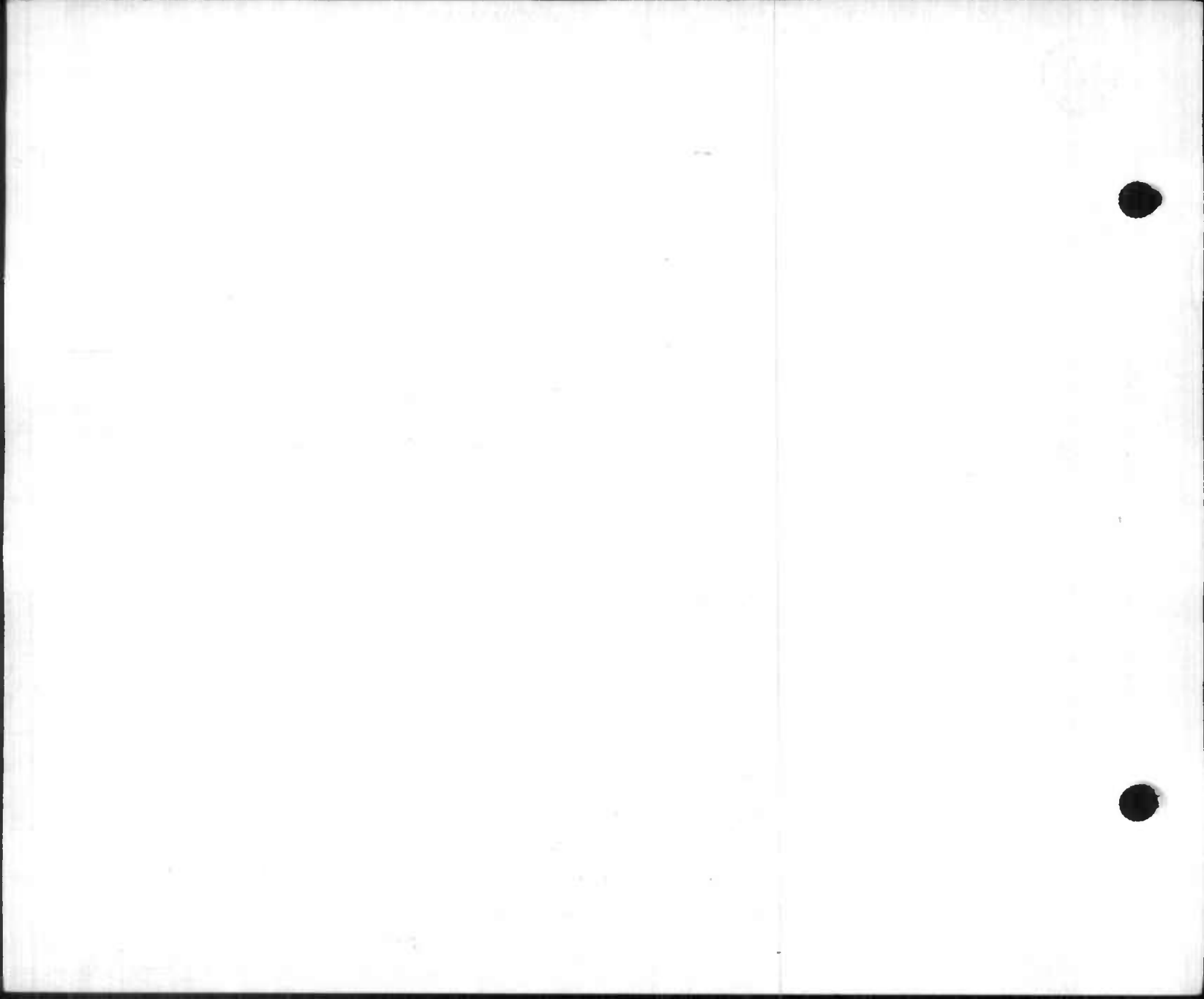
1- STATE REGISTRAR
Item 15 8565 3/4/82 83STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | | | | | | | | | | | | | | | | | |
|--|--|------------------|----------------|---|--|---|--|---|-----------------|-------------------------------|--|---|--|--|------------------|---|--|--|--|---|--|--|--|
| 1. DECEASED NAME
(TYPE OR PRINT) | | | FIRST
Henry | | | MIDDLE
Jackson | | | LAST
Jackson | | | 2a. DATE KNOWN OF DEATH
ESTIMATED
2 6 19 82 | | | 2b. HOUR
M | | | | | | | | |
| 3. SEX
male | | 4. RACE
black | | 5. DATE OF BIRTH
MONTH DAY YEAR
3 29 52 | | 6. AGE (IN YEARS)
LAST BIRTHDAY
52 YRS. | | IF UNDER 1 YR.
MONTHS DAYS | | IF UNDER 24 HRS.
HOURS MIN | | 7c. DATE PRONOUNCED DEAD
2 8 19 82 | | | 7d. HOUR
8:36 | | | | | | | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
MD | | | | 7b. CITIZEN OF WHAT COUNTRY?
USA | | | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | | | 9. BALTIMORE CITY OR COUNTY OF DEATH
Baltimore City MD | | | | AM | | | | | | | |
| 10. CITY OR TOWN OF DEATH
Baltimore | | | | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
211 N. Fremont Avenue | | | | | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | | | | 12b. KIND OF BUSINESS OR INDUSTRY | | | | | | | |
| 13a. STATE
MD | | | | 13b. COUNTY | | | | 13c. CITY OR TOWN
Baltimore | | | | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | | 13e. STREET ADDRESS
221 N. Fremont Ave. | | | | | | | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
Joseph Jackson | | | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
Carrie Mae Gurry Gray | | | | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO, OR UNKNOWN)
Yes | | | | | | | | 16b. SOCIAL SECURITY NO.
215-22-7709 | | | | 17. INFORMANT
Veronica King 2709 Giles Rd. | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I DEATH WAS CAUSED BY:
4292 IMMEDIATE CAUSE (a) Arteriosclerotic cardiovascular disease
Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.
(b) DUE TO, OR AS A CONSEQUENCE OF
(c) DUE TO, OR AS A CONSEQUENCE OF
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | | | | | | | | | | | | | | | | | | | | | | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) | | | | | | | | | | | | | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | | | | | | | | | | | | 20. AUTOPSY?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | | | | | |
| 21a. EXTERNAL CAUSE WAS
UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH | | | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) | | | | | | | | | | | | | | | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK AT WORK | | | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) | | | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | | | | | | | | | | | | | |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> . | | | | | | | | | | | | | | | | | | | | | | | |
| ACTUAL SIGNATURE
Thomas D. Smith, M.D. | | | | TITLE (SPECIFY)
Deputy Chief MEDICAL EXAMINER | | | | | | | | DATE SIGNED
2/8/82 | | | | | | | | | | | |
| EXAMINER'S NAME
(TYPE OR PRINT)
Thomas D. Smith, M.D. | | | | ADDRESS
111 Penn Street, Balto, MD 21201 | | | | | | | | | | | | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)
Burial | | | | 23b. DATE
2/16/82 | | | | 23c. NAME OF CEMETERY OR CREMATORY
Md. Veteran Cem. | | | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
Crownsville MD | | | | | | | | | | | |
| 24. FUNERAL DIRECTOR
NAME
Wm. C. March F/H | | | | ADDRESS
1101 E. North Ave. | | | | 25a. DATE REC'D. BY REGISTRAR
FEB 11 1982 | | | | 25b. REGISTRAR'S SIGNATURE
Thomas D. Smith | | | | | | | | | | | |

MEDICAL CERTIFICATION

BP



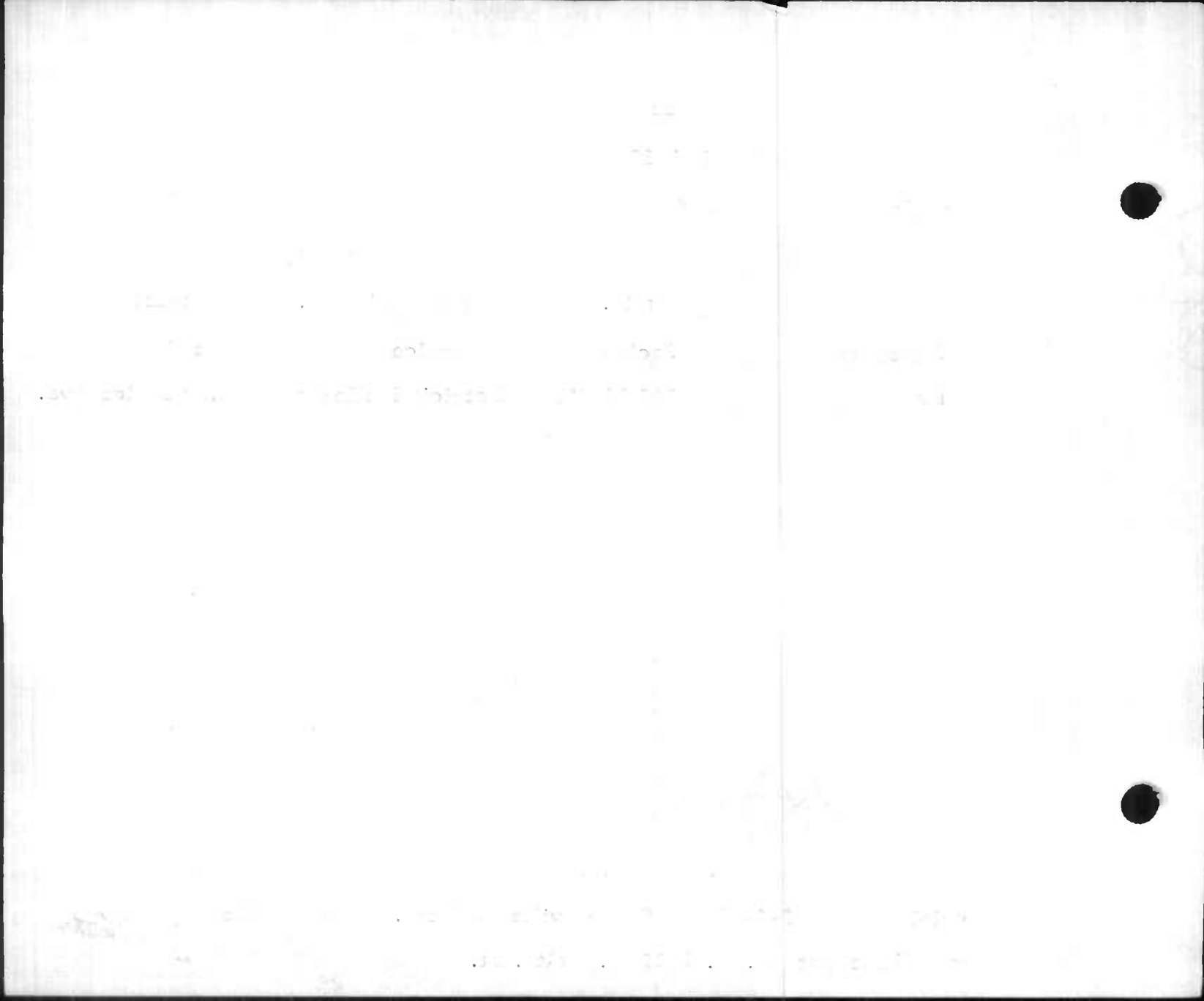
TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE FORMS 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITH FORMS 1, 2, 3, 4, 5, 6, 7, 8, 9, 10, 11, 12, 13, 14, 15, 16, 17, 18, 19, 20, 21, 22, 23, 24, 25, 26, 27, 28, 29, 30, 31, 32, 33, 34, 35, 36, 37, 38, 39, 40, 41, 42, 43, 44, 45, 46, 47, 48, 49, 50, 51, 52, 53, 54, 55, 56, 57, 58, 59, 60, 61, 62, 63, 64, 65, 66, 67, 68, 69, 70, 71, 72, 73, 74, 75, 76, 77, 78, 79, 80, 81, 82, 83, 84, 85, 86, 87, 88, 89, 90, 91, 92, 93, 94, 95, 96, 97, 98, 99, 100.

BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | | | | | | | | | |
|--|--|---|--|---|--|---------------------------------------|--|--|--|---------------------|--|--------------------------|--|---------------------|--|
| 1- STATE REGISTRAR | | FOR | | 2 | | 0 | | 3 | | 8 | | 6 | | 9 | |
| 1. DECEASED NAME
(TYPE OR PRINT) | | FIRST | | MIDDLE | | LAST | | 2a. DATE KNOWN OF DEATH | | MONTH | | DAY | | YEAR | |
| Mannie Lee Jackson | | | | | | | | XX | | 2 | | 26 | | 19 82 | |
| 3. SEX | | 4. RACE | | 5. DATE OF BIRTH | | 6. AGE (IN YEARS) | | IF UNDER 1 YR. | | IF UNDER 24 HRS. | | 7c. DATE PRONOUNCED DEAD | | 2d. HOUR | |
| male | | black | | 9 13 1932 | | 49 YRS. | | | | | | 2 | | 26 19 82 4:55 | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) | | 7b. CITIZEN OF WHAT COUNTRY? | | 8. MARRIED | | NEVER MARRIED | | 9. BALTIMORE CITY OR COUNTY OF DEATH | | PM | | | | | |
| Maryland | | USA | | WIDOWED | | DIVORCED | | Baltimore City | | MD | | | | | |
| 10. CITY OR TOWN OF DEATH | | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | | 12b. KIND OF BUSINESS OR INDUSTRY | | | | | | | | | |
| Baltimore | | University Hospital | | Disable | | | | | | | | | | | |
| USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) | | 13a. STATE | | 13b. COUNTY | | 13c. CITY OR TOWN | | 13d. INSIDE CITY LIMITS? | | 13e. STREET ADDRESS | | | | | |
| Md | | Balto. | | | | YES | | NO | | 148 W. Cross Street | | | | | |
| 14. FATHER'S NAME | | MIDDLE | | LAST | | 15. MOTHER'S MAIDEN NAME | | MIDDLE | | LAST | | | | | |
| Anderson | | Jackson | | Eunice | | Lewis | | | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? | | 16b. SOCIAL SECURITY NO. | | 17. INFORMANT | | ADDRESS | | | | | | | | | |
| No | | 213 26 7114 | | Patricia Mellerson | | 18 N. Bernice Ave. | | | | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) | | PART I DEATH WAS CAUSED BY: | | IMMEDIATE CAUSE (a) | | DUE TO, OR AS A CONSEQUENCE OF | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | | | | | | |
| 9651 | | Shotgun wound of abdomen | | | | | | | | | | | | | |
| Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. | | (b) | | DUE TO, OR AS A CONSEQUENCE OF | | | | | | | | | | | |
| | | (c) | | | | | | | | | | | | | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) | | | | | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | | 20. AUTOPSY? | | YES | | NO | | | | | | | |
| | | | | YES | | NO | | | | | | | | | |
| 21a. EXTERNAL CAUSE WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH | | 21b. TIME OF INJURY | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2) | | | | | | | | | | | |
| | | 9:15 PM 12/2 19 81 | | subject shot | | | | | | | | | | | |
| 21d. INJURY OCCURRED WHILE AT WORK | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) | | 21f. LOCATION | | CITY OR TOWN | | COUNTY | | STATE | | | | | |
| NOT WHILE AT WORK | | house | | 145 West Hamberg St. apt 5 | | Balto., MD | | | | | | | | | |
| 22a. I certify that I took charge of the remains described above, held an autopsy | | Inspection | | Inquiry | | and in my opinion death resulted from | | Accident | | Suicide | | Homicide | | Undetermined manner | |
| | | XX | | | | | | | | | | | | | |
| ACTUAL SIGNATURE | | TITLE (SPECIFY) | | DATE SIGNED | | | | | | | | | | | |
| Hormez R. Guard, M.D. | | Assistant | | 2/27/82 | | | | | | | | | | | |
| EXAMINER'S NAME (TYPE OR PRINT) | | ADDRESS | | | | | | | | | | | | | |
| Hormez R. Guard, M.D. | | 111 Penn Street, Balto., MD 21201 | | | | | | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) | | 23b. DATE | | 23c. NAME OF CEMETERY OR CREMATORY | | 23d. LOCATION | | CITY OR TOWN | | COUNTY | | STATE | | | |
| Burial | | 3-3-82 | | Crownsville VA Cem. | | Crownsville | | | | | | | | | |
| 24. FUNERAL DIRECTOR NAME | | ADDRESS | | 25a. DATE REC'D. BY REGISTRAR | | 25b. REGISTRAR'S SIGNATURE | | | | | | | | | |
| Brown/Thompson F. H. | | 1913 W. Balto. St. | | MAR 2 1982 | | James J. [Signature] | | | | | | | | | |



MAY 1984 46 A

JACKSON, SAMUEL A

DHMH - 16 50M 1/81
(VRA 15, 4)1 - FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 2 0 3 8 7 0

REG. NO.

| | | | | | |
|--|--|---|---|--|--|
| 1. DECEASED NAME
(TYPE OR PRINT)
Samuel A Jackson | | | 2a. DATE OF DEATH
MONTH DAY YEAR
Feb 8th 1982 | | 2b. HOUR
3:50P
M |
| 3. SEX
Male | 4. RACE
Black | 5. DATE OF BIRTH
MONTH DAY YEAR
2/24/1937 | | 6. AGE (IN YEARS LAST BIRTHDAY)
44
YRS. | IF UNDER 1 YEAR
MONTHS DAYS
IF UNDER 24 HRS.
HOURS MIN. |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
Baltimore Md. | 7b. CITIZEN OF WHAT COUNTRY?
U. S. A. | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
Baltimore City MD. | |
| 10. CITY OR TOWN OF DEATH
Baltimore | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
John Hopkins Hospital | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
Laborer | | 12b. KIND OF BUSINESS OR INDUSTRY
0 |
| 13a. STATE
Md. | | | 13b. COUNTY | 13c. CITY OR TOWN
Baltimore | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
Joseph Thomas | | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
Fannie Tyler | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
Yes C-26760637 | | 16b. SOCIAL SECURITY NO.
(IF YES, GIVE WAR OR DATES) | | 17. INFORMANT
ADDRESS
Alice Jackson, 1132 N Fulton Ave. | |
| 18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c).
PART 1. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>CARDIO RESPIRATORY ARREST</u>
<u>5-850</u>
DUE TO, OR AS A CONSEQUENCE OF
(b) <u>UREMIA</u>
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(c) <u>RENAL FAILURE (CHRONIC)</u> | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
<u>ONE HOUR</u>
<u>3 DAYS</u>
<u>MONTHS</u> |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: 0 | | | | | |
| 19a. DATE OF OPERATION
1/20/82 | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED
LOWER G.I. HEMORRHOIDS | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | |
| 21d. INJURY OCCURRED
WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>12/1/81</u> , 19 <u>81</u> , to <u>2/8</u> , 19 <u>82</u> , that (I) (we) lost saw the deceased alive on <u>2/8 3:50PM</u> , 19 <u>82</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | |
| 22b. SIGNATURE
<u>Gregory R. Criscuolo</u> | | DEGREE
ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> | | 22c. DATE SIGNED | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
GREGORY R. CRISCUOLO | | 22e. ADDRESS
550 N. BROADWAY # 911 | | | |
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)
Burial | 23b. DATE
2/13/82 | 23c. NAME OF CEMETERY OR CREMATORY
Arbutus Mem Pk | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
Baltimore, Md. | |
| 24. FUNERAL DIRECTOR
NAME
Law Funeral Home 4611 Park Heights Ave. | | 25a. DATE RECD. BY REGISTRAR
FEB 11 1982 | | 25b. REGISTRAR'S SIGNATURE
<u>James J. [Signature]</u> | |

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. The physician or attending physician retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, it should be detached for use as the burial transit permit. These please remove carbon copies. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1604

203:1

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be removed by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 4 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

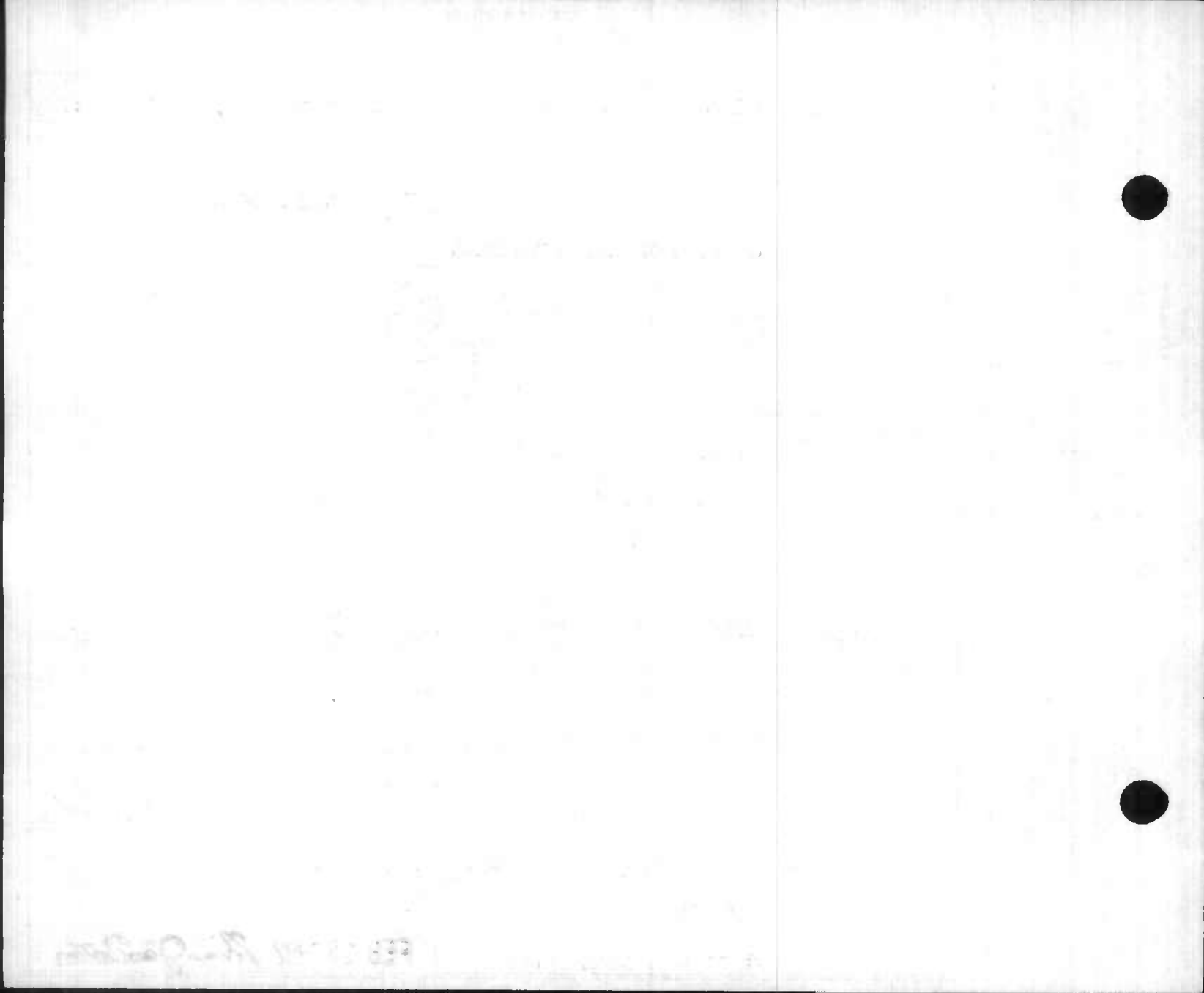
IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 2 0 3 8 7 1

REG. NO.

| | | | | | |
|---|--|---|--|--|--|
| 1. DECEASED NAME
(TYPE OR PRINT)
Renee M. BABY GIRL JAMES | | 2a. DATE OF DEATH
MONTH DAY YEAR
February 13, 1982 | | 2b. HOUR
2:34p | |
| 3. SEX
female | 4. RACE
black | 5. DATE OF BIRTH
MONTH DAY YEAR
3 31 1981 | | 6. AGE (IN YEARS LAST BIRTHDAY)
YRS. MONTHS DAYS
11 | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
Md | 7b. CITIZEN OF WHAT COUNTRY?
USA | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
BALTIMORE CITY MD | |
| 10. CITY OR TOWN OF DEATH
Baltimore | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
JOHNS HOPKINS HOSPITAL | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE) | |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)
STATE CITY OR TOWN
Md Baltimore | | 13b. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13c. STREET ADDRESS
1809 E. Biddle Street | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
Samuel James | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
Renee M. Brown | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
No | | 16b. SOCIAL SECURITY NO.
----- | | 17. INFORMANT ADDRESS
Samuel James 2007 Forest Hgt Drive | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART 1. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) G.I. HEMORRHAGE
7651
DUE TO, OR AS A CONSEQUENCE OF
(b) LIVER FAILURE
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(c) PREMATURITY, NECROTIZING ENTEROCOLITIS. | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) | | | | | |
| 19a. DATE OF OPERATION
MULTIPLE | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED
NECROTIZING ENTEROCOLITIS | | 20a. AUTOPSY?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | |
| 22a. I certify that (this hospital) attended the deceased from 3-31 , 19 81 , to 2-13 , 19 82 , that (we) last saw the deceased alive on 2-13 , 19 82 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | |
| 22b. SIGNATURE
Peter C. Rowe MD | | DEGREE
MD | | 22c. DATE SIGNED
2-13-82 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
PETER C. ROWE | | 22e. ADDRESS
JOHNS HOPKINS HOSP. BALTO MD 21205 | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)
Burial | | 23b. DATE
2/19/82 | | 23c. NAME OF CEMETERY OR CREMATORY
Cedar Hill Cemetery | |
| 24. FUNERAL DIRECTOR
NAME
William C. March F/H 1101 E. North Avenue | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
Anne Arundel Co Md | | 25a. DATE REC'D. BY REGISTRAR
FEB 17 1982 | |
| | | | | 25b. REGISTRAR'S SIGNATURE
<i>[Signature]</i> | |



STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 2 0 3 8 7 2

1 - FOR
STATE
REGISTRAR

REG. NO.

| | | | | | | |
|--|-------------------------|---|--|--|-------------------------|--|
| 1. DECEASED NAME
(TYPE OR PRINT)
FIRST MIDDLE LAST
DUJUAN DEXTER Jarrett | | | 2a. DATE OF DEATH
MONTH DAY YEAR
2/1/82 | | 2b. HOUR
926p | |
| 3. SEX
MALE | 4. RACE
NEGRO | 5. DATE OF BIRTH
MONTH DAY YEAR
2 1 82 | | 6. AGE (IN YEARS LAST BIRTHDAY)
0 YRS 0 MONTHS 0 DAYS 0 HRS 0 MIN | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
BALT., MARYLAND | | 7b. CITIZEN OF WHAT COUNTRY?
U.S.A. | | 9. BALTIMORE CITY OR COUNTY OF DEATH
BALTIMORE CITY MD. | | |
| 10. CITY OR TOWN OF DEATH
BALTIMORE | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
BALTIMORE CITY HOSPITAL | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
DNA | | |
| 13a. STATE
MARYLAND | | 13b. COUNTY
PRINCE GEORGE | | 13c. CITY OR TOWN
HYATTSVILLE | | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
WILLIAM E. JARRETT JR. | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
SABRINA EDWARDS | | 16. SOCIAL SECURITY NO.
NA | | |
| 17. INFORMANT
WILLIAM E. JARRETT JR. | | 18. ADDRESS
SAME AS ABOVE | | 19. DATE OF OPERATION
1982 | | |
| 20a. AUTOPSY?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 21. LOCATION
STREET CITY OR TOWN COUNTY STATE
B.C.H. | | |
| 22a. SIGNATURE
H. Hwu M.D. | | 22b. PHYSICIAN'S NAME (TYPE OR PRINT)
H. Hwu | | 22c. DATE SIGNED
Feb. 1, 82 | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)
BURIAL | | 23b. DATE
2/5/82 | | 23c. NAME OF CEMETERY OR CREMATORY
GREEN ACRES MEM. PARK | | |
| 24. FUNERAL DIRECTOR
NAME ADDRESS
Spelley Mem. Chapel Rt 42 Salis Md | | 25. DATE REC'D. BY REGISTRAR
FEB 16 1982 | | 26. COUNTY
WICOMICO, MARYLAND | | |

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY

IMMEDIATE CAUSE (a) **bradycardia**
7597
 DUE TO, OR AS A CONSEQUENCE OF
 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
 (b) **prematurity**
 DUE TO, OR AS A CONSEQUENCE OF
 (c) **multiple congenital anomalies**

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a):

19a. DATE OF OPERATION

19b. CONDITION FOR WHICH OPERATION WAS PERFORMED

20a. AUTOPSY?

20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?

21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19

21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)

21d. INJURY OCCURRED
WHILE AT WORK ☐ NOT WHILE AT WORK ☐21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)21f. LOCATION
STREET CITY OR TOWN COUNTY STATE

22a. I certify that (I) (this hospital) attended the deceased from **Feb 1**, 19 **82**, to **Feb 1**, 19 **82**, that (I) (we) lost saw the deceased alive on **Feb 1**, 19 **82**, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE

DEGREE

ATTENDING PHYSICIAN ☐ MEDICAL DIRECTOR ☐ STAFF PHYSICIAN ☒

22c. DATE SIGNED

22d. PHYSICIAN'S NAME (TYPE OR PRINT)

22e. ADDRESS

23a. BURIAL, CREMATION, REMOVAL (SPECIFY)
BURIAL

23b. DATE

23c. NAME OF CEMETERY OR CREMATORY

23d. LOCATION
CITY OR TOWN COUNTY STATE

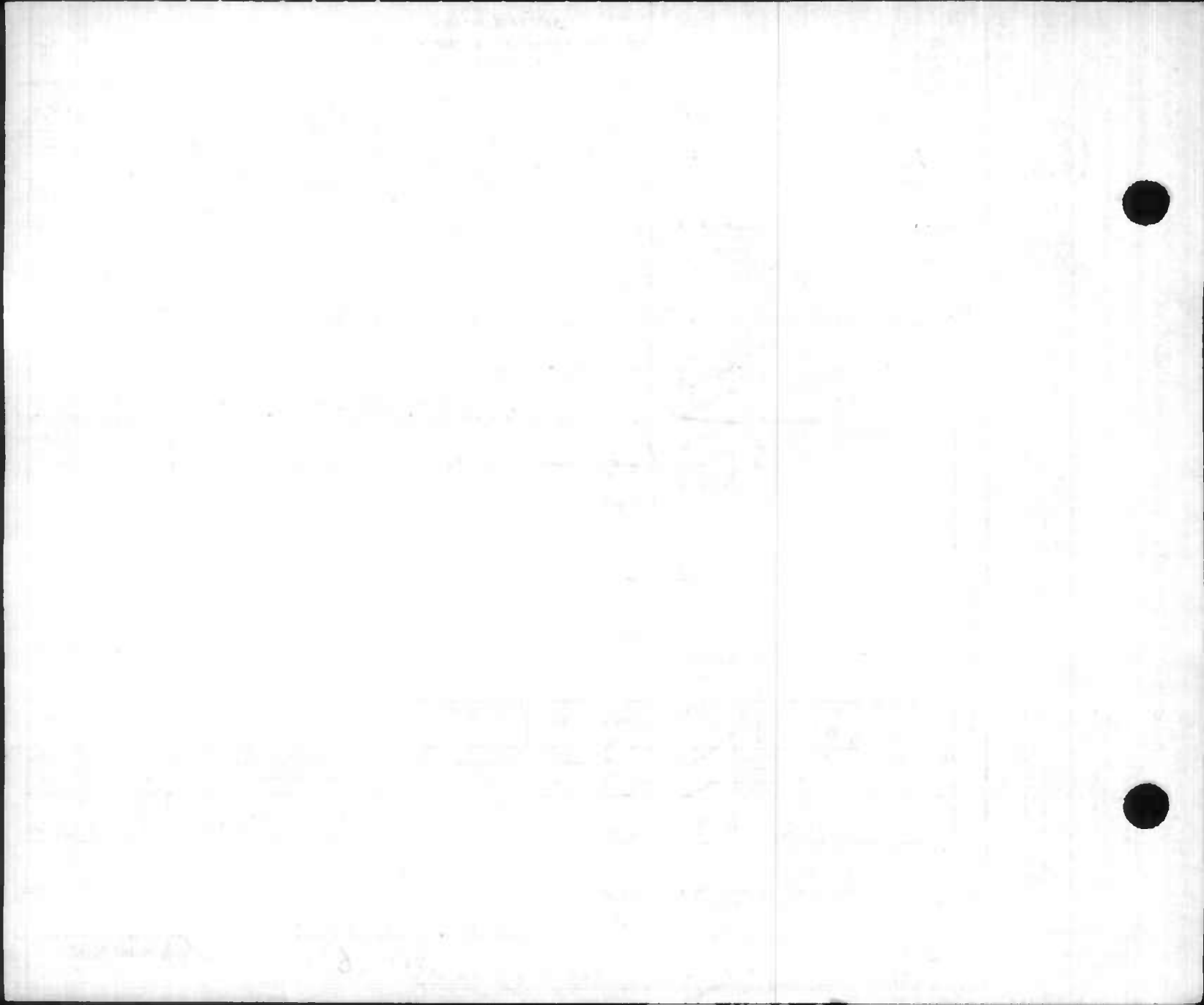
24. FUNERAL DIRECTOR

25. DATE REC'D. BY REGISTRAR

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. It may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours of death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death and retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 2 0 3 8 7 3

REG. NO.

| | | | | | | | | | | | |
|---|--|---|--|---|--|---|--|--|--|---|--|
| 1. DECEASED NAME (Type or Print)
(Issac) Demar | | FIRST
I. | | MIDDLE
Jefferson | | LAST | | 2a. DATE OF DEATH
MONTH
2 DAY
15 YEAR
82 | | 2b. HOUR
M | |
| 3. SEX
Male | | 4. RACE
Black | | 5. DATE OF BIRTH
MONTH
9 DAY
9 YEAR
05 | | 6. AGE (IN YEARS LAST BIRTHDAY)
76 | | IF UNDER 1 YEAR
MONTHS
YRS | | IF UNDER 24 HRS
HOURS
MIN. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
MD | | 7b. CITIZEN OF WHAT COUNTRY?
USA | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
Baltimore City MD. | | | | | |
| 10. CITY OR TOWN OF DEATH
Baltimore | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
2503 Violet Ave Apt. 709 | | | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | | 12b. KIND OF BUSINESS OR INDUSTRY | |
| 13a. STATE
MD | | 13b. COUNTY | | 13c. CITY OR TOWN
Baltimore | | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS
2503 Violet Avenue | | | |
| 14. FATHER'S NAME
FIRST
John MIDDLE
Jefferson LAST | | 15. MOTHER'S MAIDEN NAME
FIRST
Ella MIDDLE
Dett LAST | | | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)
No | | 16b. SOCIAL SECURITY NO.
212-16-3961 | | 17. INFORMANT ADDRESS
Geraldine Washington 4408 Mountview Rd | | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
4100 IMMEDIATE CAUSE (a) Myocardial Infarction
DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b) ASHD
DUE TO, OR AS A CONSEQUENCE OF
(c) Natural Aging process
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | | | | | |
| 21d. INJURY OCCURRED
WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET
2200 GUTAW PLACE | | CITY OR TOWN
Reisterstown | | COUNTY
Harford | | STATE
MD | |
| 22a. I certify that (I) (the hospital) attended the deceased from 10-30 , 19 80 , to 2-8 , 19 82 , that (I) (we) last saw the deceased alive on 2-8 , 19 82 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | | | |
| 22b. SIGNATURE
Frank W. Washington, M.D. | | | | | | DEGREE
M.D. | | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | 22c. DATE SIGNED
2-18-82 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
FRANK W. WASHINGTON, M.D. | | | | | | 22e. ADDRESS
2200 GUTAW PLACE 21217 | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)
Burial | | 23b. DATE
2/20/82 | | 23c. NAME OF CEMETERY OR CREMATORY
Piney Grove Cem. | | 23d. LOCATION
CITY OR TOWN
Reisterstown | | COUNTY
Harford | | STATE
MD | |
| 24. FUNERAL DIRECTOR
NAME
Wm C. March F/H | | | | | | ADDRESS
1101 E. North Ave. | | 25a. DATE REC'D. BY REGISTRAR
FEB 19 1982 | | | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Possession be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, Page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified first.

BP

DHMH-16 30M 2/80
(VRA 15, 4)

FOR
1 - STATE
REGISTRAR

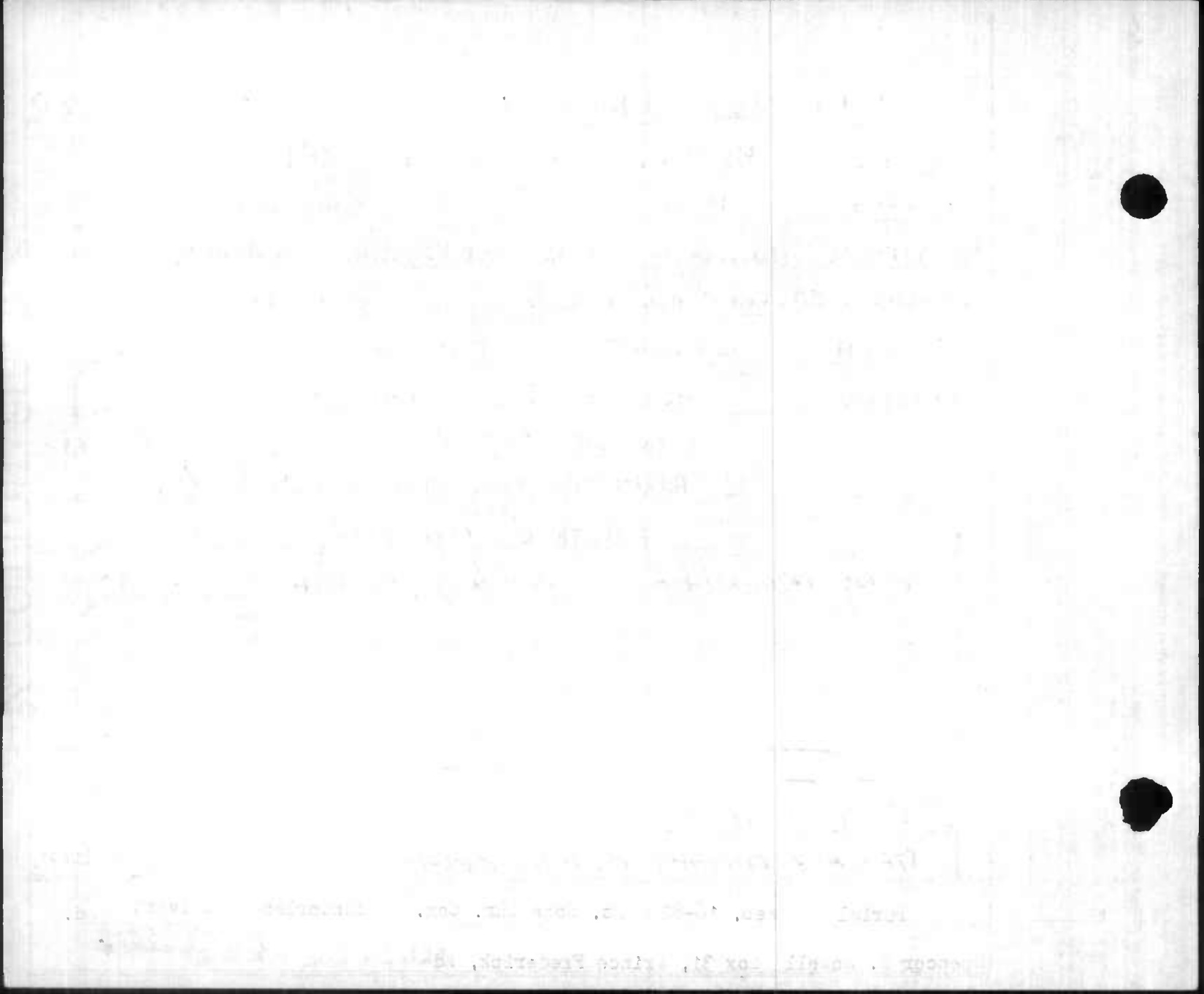
STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 2 0 3 8 7 4

REG. NO.

| | | | | | | | | | | |
|--|--|---|--|---|--|--|--|--|--------------------------------------|--|
| 1. DECEASED NAME
(TYPE OR PRINT) JENNINGS, INEZ W. | | | 2a. DATE OF DEATH
MONTH DAY YEAR
2-11-82 | | | 2b. HOUR
8:30 P.M. | | | | |
| 3. SEX
FEMALE | | 4. RACE
BLACK | | 5. DATE OF BIRTH
MONTH DAY YEAR
5-15-14 | | 6. AGE (IN YEARS LAST BIRTHDAY)
67 YRS. | | 7. IF UNDER 1 YEAR
MONTHS DAYS
IF UNDER 24 HRS.
HOURS MIN. | | |
| 7a. BIRTHPLACE
(STATE OR FOREIGN COUNTRY)
TEXAS | | 7b. CITIZEN OF WHAT COUNTRY?
U.S. | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
BALTIMORE CITY MD. | | | | |
| 10. CITY OR TOWN OF DEATH
BALTIMORE | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
UNIVERSITY OF MARYLAND HOSPITAL | | | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
TEACHER | | 12b. KIND OF BUSINESS OR INDUSTRY
ELEM. ED. | | |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)
13a. STATE
MARYLAND | | | 13b. COUNTY
CALVERT | | 13c. CITY OR TOWN
HUNTINGTOWN | | 13d. INSIDE CITY LIMITS?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS
BOX 92 | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
JOSEPH WRIGHT | | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
MISSIE SIMPSON | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)
UNKNOWN | | | 16b. SOCIAL SECURITY NO.
462-34-7986 | | 17. INFORMANT
ADDRESS
PATIENT | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART 1. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) FUNGAL SEPSIS
2050
DUE TO, OR AS A CONSEQUENCE OF (b) ACUTE MYELOMONOCYTIC LEUKEMIA
AND
DUE TO, OR AS A CONSEQUENCE OF (c) MULTIPLE MYELOMA
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last }
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
1 week
months | | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)
ADENOCARCINOMA OF BREAST, SCIRROUS COLLOID | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | | | |
| 21d. INJURY OCCURRED
WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | | | |
| 22a. I certify that (I) (the hospital) attended the deceased from January 5, 1982 to February 11, 1982 , that (I) (we) last saw the deceased alive on February 11, 1982 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (If (we) did not view the body after death, so state.) | | | | | | | | | | |
| 22b. PHYSICIAN'S NAME (TYPE OR PRINT)
STEWART, MICHAEL B., M.D. | | | | | | DEGREE
BALTIMORE CANCER RESEARCH CTR. | | 22c. DATE SIGNED | | |
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)
Burial | | | 23b. DATE
Feb. 16-82 | | 23c. NAME OF CEMETERY OR CREMATORY
Mt. Hope Chr. Cem. | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
Sunderland Calvert Md. | | | |
| 24. FUNERAL DIRECTOR
NAME
Spencer E. Sewell | | | | | | 25a. DATE REC'D. BY REGISTRAR
FEB 17 1982 | | | | |
| ADDRESS
Box 31, Prince Frederick, Md. | | | | | | REGISTRAR'S SIGNATURE
<i>[Signature]</i> | | | | |

MEDICAL CERTIFICATION



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 must be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

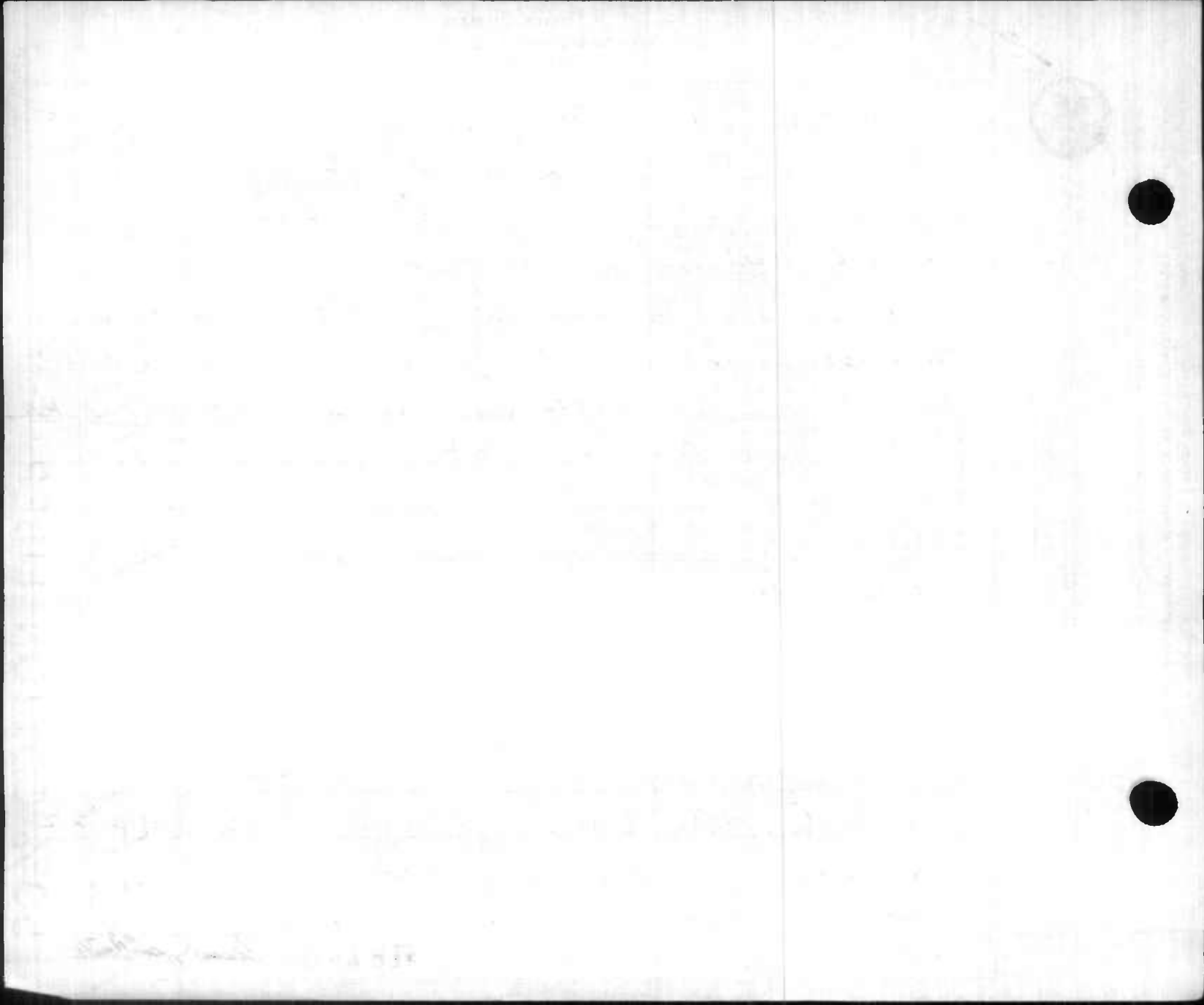
STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 2 0 3 8 7 5

1. FOR
STATE
REGISTRAR

REG. NO.

| | | | | | | | |
|---|--|--|---|---|---|---|--|
| 1. DECEASED NAME
(TYPE OR PRINT)
FIRST MIDDLE LAST
<i>Malinda R Jennings</i> | | | 2a. DATE OF DEATH
MONTH DAY YEAR
<i>2 18 82</i> | | | 2b. HOUR
<i>2:25 M</i> | |
| 3. SEX
<i>F</i> | | 4. RACE
<i>B</i> | | 5. DATE OF BIRTH
MONTH DAY YEAR
<i>12 26 15</i> | | 6. AGE (IN YEARS LAST BIRTHDAY)
<i>66</i> | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
<i>Virginia</i> | | 7b. CITIZEN OF WHAT COUNTRY?
<i>U.S.A.</i> | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
<i>City</i> MD. | |
| 10. CITY OR TOWN OF DEATH
<i>Baltimore</i> | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
<i>University of Maryland</i> | | | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
<i>City</i> | |
| 13a. STATE
<i>MD</i> | | 13b. COUNTY | | 13c. CITY OR TOWN
<i>Baltimore</i> | | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
<i>Jennings James</i> | | | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
<i>Bessie Campbell</i> | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN) <i>No</i> | | 16b. SOCIAL SECURITY NO.
<i>214-24-2056</i> | | 17. INFORMANT
ADDRESS
<i>James Jennings 1813 Arunah Ave</i> | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART 1. DEATH CAUSED BY:
<i>4275</i> IMMEDIATE CAUSE (a) <i>Cardiac Arrest</i>
DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b) _____
DUE TO, OR AS A CONSEQUENCE OF
(c) _____ | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)
<i>lung cancer</i> | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
<i>P.M. 19</i> | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | |
| 21d. INJURY OCCURRED
WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from <i>2/18/82</i> , 19____, to _____, 19____, that (I) (we) last saw the deceased alive on _____, 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | |
| 22b. SIGNATURE
<i>E Huxley Miller Jr MD</i> | | | | DEGREE
ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | 22c. DATE SIGNED
<i>2/18/82</i> | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
<i>E Huxley Miller Jr</i> | | | | 22e. ADDRESS
<i>University Hospital</i> | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)
<i>Burial</i> | | 23b. DATE
<i>2/22/82</i> | | 23c. NAME OF CEMETERY OR CREMATORY
<i>Griffin Cemetery</i> | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
<i>Crewe, Va.</i> | |
| 24. FUNERAL DIRECTOR
NAME ADDRESS
<i>1101 E. North Ave. Wm C March F/H</i> | | | | 25a. DATE REC'D BY REGISTRAR
<i>FEB 22 1982</i> | | | |



TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed in the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

BP

DHMH-16 30M 2/80
(VRA 15, 4)

| STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE | | | | 8-2 03876 | |
|--|---|---|---|---|--|
| 1. FOR STATE REGISTRAR | | | | REG. NO. | |
| 1. DECEASED NAME (TYPE OR PRINT)
FIRST MIDDLE LAST
IAN JEWITT | | | 2a. DATE OF DEATH MONTH DAY YEAR
FEBRUARY 6, 1982 | | 2b. HOUR
3:10 AM |
| 3. SEX
Male | 4. RACE
White | 5. DATE OF BIRTH MONTH DAY YEAR
Jan. 21, 1935 | | 6. AGE (IN YEARS LAST BIRTHDAY) YRS. MONTHS DAYS
47 | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
Australia | 7b. CITIZEN OF WHAT COUNTRY?
Australia | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
BALTIMORE CITY MD. | |
| 10. CITY OR TOWN OF DEATH
Baltimore | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
JOHNS HOPKINS HOSPITAL | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)
Teacher | | 12b. KIND OF BUSINESS OR INDUSTRY
School |
| 13a. STATE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)
Maryland | | | 13b. COUNTY
Carroll | 13c. CITY OR TOWN
Millers | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 14. FATHER'S NAME FIRST MIDDLE LAST
William Roy Jewitt | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST
Margaret Corrie Short | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)
No | | 16b. SOCIAL SECURITY NO.
524 82 0846 | | 17. INFORMANT ADDRESS
Neil J. Ruthers, Balto., Md. | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART 1. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) CARDIO RESPIRATORY ARREST
2020
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b) HYPERCALCEMIA
DUE TO, OR AS A CONSEQUENCE OF
(c) ADOLAR POORLY DIFFERENTIATED LYMPHOMA IV B
33 MOS
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
5 min
12 DAYS | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)
THROMBOCYTOPENIA, INFECTED L SUPRACILIACULAR MASS | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR
19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION CITY OR TOWN COUNTY STATE | |
| 22a. I certify that (this hospital) attended the deceased from JAN 25 , 19 82 , to FEB 6 , 19 82 , that (I) (we) lost saw the deceased alive on FEB 6, 3:10 AM , 19 82 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | |
| 22b. SIGNATURE
Anastasio R de Castro | | DEGREE | | 22c. DATE SIGNED
FEB 6 1982 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
ANASTASIO R DE CASTRO | | 22e. ADDRESS
JOHNS HOPKINS HOSPITAL | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)
Burial | | 23b. DATE
2/8/82 | | 23c. NAME OF CEMETERY OR CREMATORY
Gunpowder Meeting House, Sparks, Md. | |
| 24. FUNERAL DIRECTOR NAME
Henry W. Jenkins & Sons Co. | | 24b. ADDRESS
4905 York Road Balto., Md. 21212 | | 25a. DATE REC'D. BY REGISTRAR
FEB 8 1982 | |
| | | 25b. REGISTRAR'S SIGNATURE
Rene J. North | | | |

The following is a list of the names of the persons who have been
 named in the report of the Committee on the subject of the
 proposed amendment to the Constitution of the State of New York.
 The names are given in the order in which they were named in the
 report.

The following is a list of the names of the persons who have been
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 The names are given in the order in which they were named in the
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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

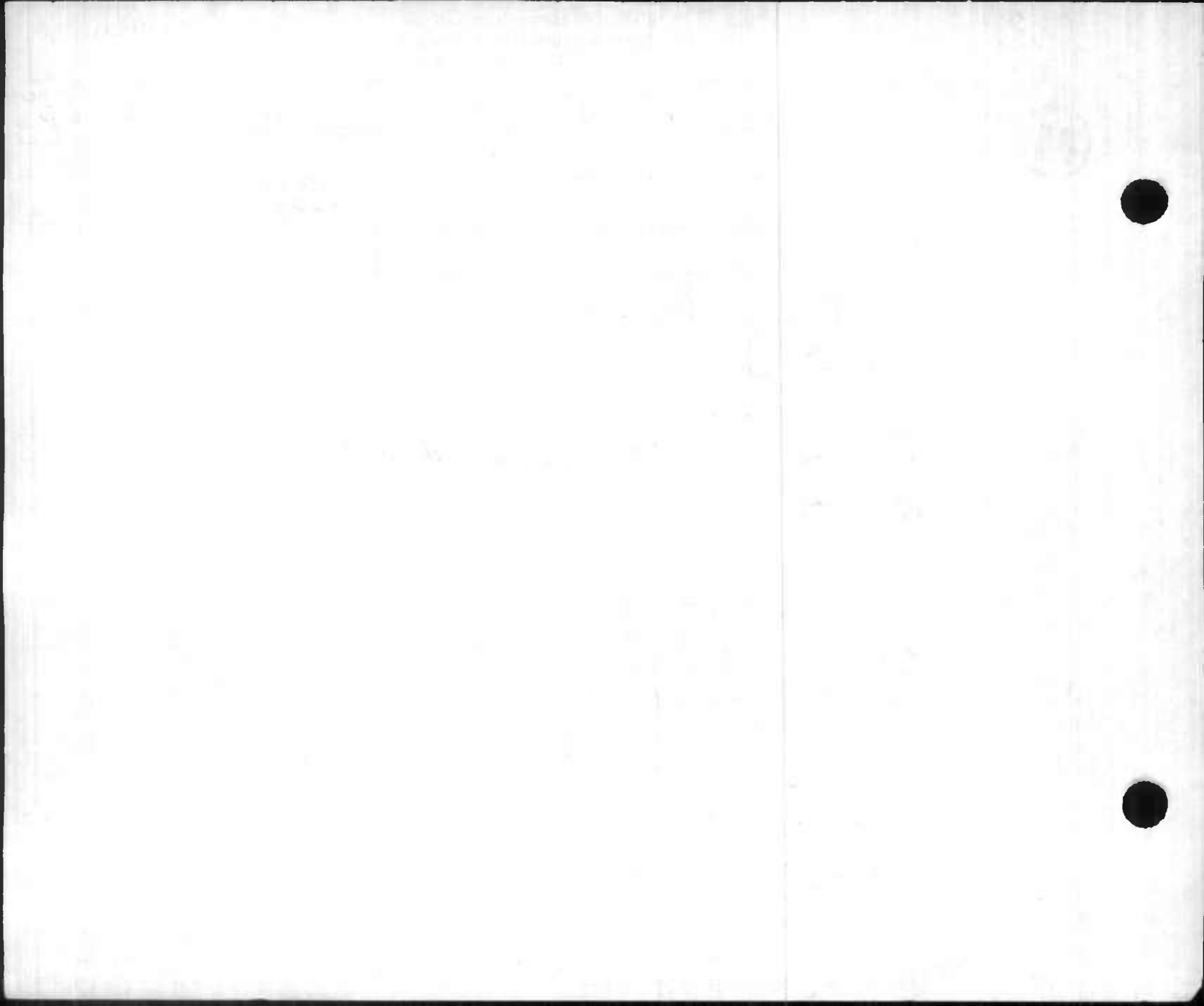
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
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1- STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

8 214-08319647

| | | | | | | | |
|--|--|--|---|--|--------------------------------------|--|--|
| 1 DECEASED NAME
(TYPE OR PRINT)
FIRST MIDDLE LAST
EMMITT H. JOHNSON | | | 2a. DATE OF DEATH
MONTH DAY YEAR
Feb. 3 - 82 | | 2b. HOUR
6²⁰ PM | | |
| 3 SEX
Male | | 4 RACE
Black | | 5. DATE OF BIRTH
MONTH DAY YEAR
5 7 00 | | 6 AGE (IN YEARS LAST BIRTHDAY)
81
YRS MONTHS DAYS HOURS MIN | |
| 7a BIRTHPLACE (STATE OR FOREIGN COUNTRY)
GA | | 7b CITIZEN OF WHAT COUNTRY?
USA | | 8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9 BALTIMORE CITY OR COUNTY OF DEATH
BALTO. City MD | |
| 10 CITY OR TOWN OF DEATH
BALTO. | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
Provident Hospital | | | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE) | |
| 13a. STATE
MD | | 13b. COUNTY | | 13c. CITY OR TOWN
Baltimore | | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 14 FATHER'S NAME
FIRST MIDDLE LAST
Walker Johnson | | 15 MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
Lucy | | 13e. STREET ADDRESS
1102 Druid Hill Avenue | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
No | | 16b. SOCIAL SECURITY NO.
214-18-1964 | | 17 INFORMANT
ADDRESS
Gladys J. Saunders 4011 Aragon Ave. | | | |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY
IMMEDIATE CAUSE (a) Ca. of Lung
1629
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last }
(b) _____
(c) _____
DUE TO, OR AS A CONSEQUENCE OF | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 70a. AUTOPSY?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | 70b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK AT WORK | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | |
| 22a. I certify that (1) (this hospital) attended the deceased from 2-2-82 to 2-3-82 , that (1) (we) lost
saw the deceased alive on 2-3-82 , and that in my (our) opinion death occurred on the date and hour and from the causes stated
above, (1) (we) did (did not) view the body after death. | | | | | | | |
| 22b. SIGNATURE
H. Devadoss | | DEGREE
MD | | ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> | | 22c. DATE SIGNED
2-3-82 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
H. Devadoss | | 22e. ADDRESS
Provident Hospital | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)
Burial | | 23b. DATE
2/6/82 | | 23c. NAME OF CEMETERY OR CREMATORY
Arbutus Me. Pk. | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
Baltimore Co. MD | |
| 24 FUNERAL DIRECTOR
NAME ADDRESS
Wm. C. March F/H 1101 E. North Ave. | | | | 25a. DATE REC'D. BY REGISTRAR
FEB 5 1982 | | 25b. REGISTRAR'S SIGNATURE
<i>Thomas J. [Signature]</i> | |

MEDICAL CERTIFICATION



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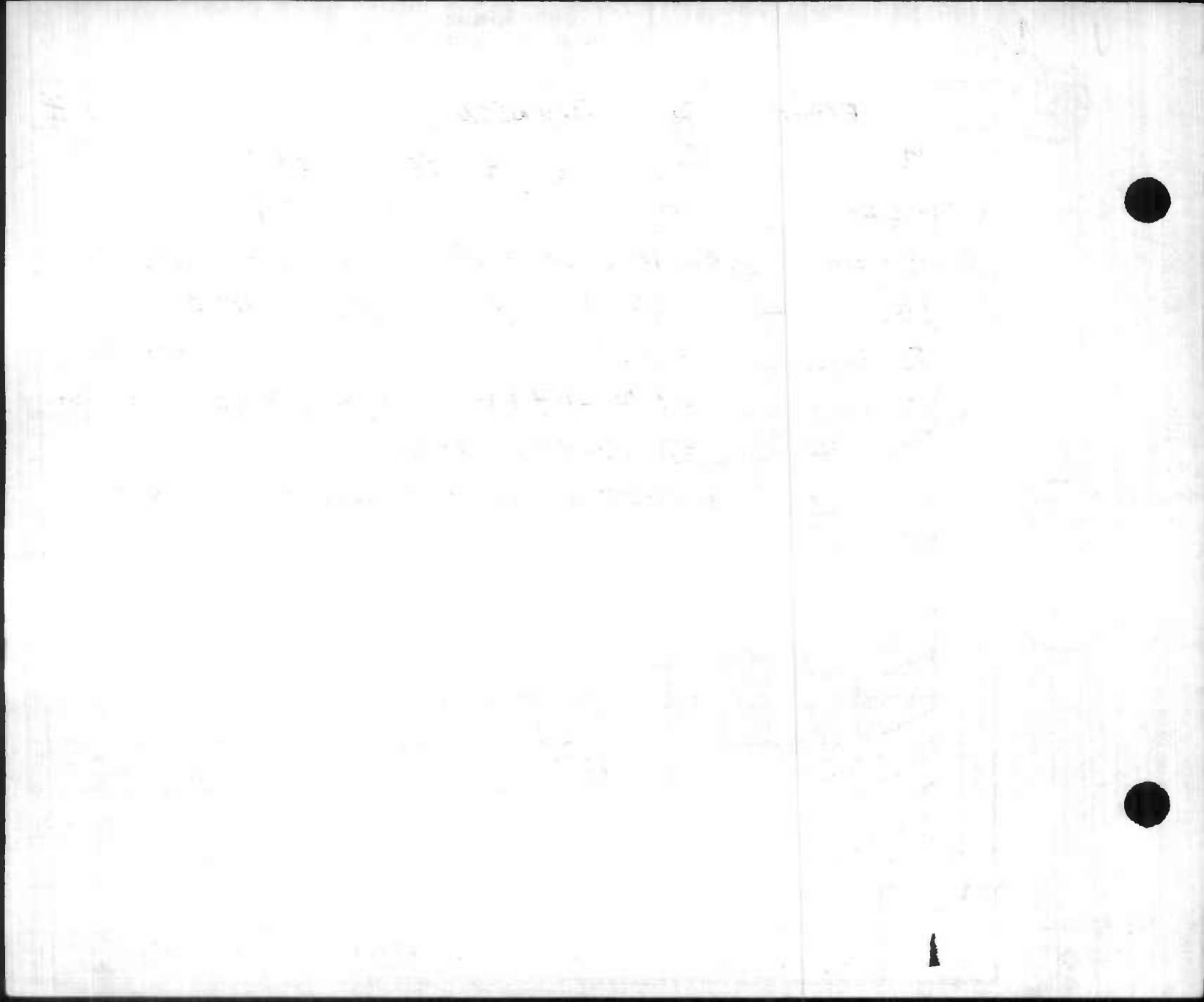
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STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 2 0 3 8 7 8

| | | | | | |
|--|---------|--|--------|--|--|
| 1. FOR STATE REGISTRAR | | 2a. DATE OF DEATH | | 2b. HOUR | |
| 1. DECEASED NAME (TYPE OR PRINT) | | 2a. DATE OF DEATH | | 2b. HOUR | |
| FIRST MIDDLE LAST | | MONTH DAY YEAR | | HOUR MIN. | |
| FRANK R JOHNSON | | 2 10 82 | | 9 30 AM | |
| 3. SEX | 4. RACE | 5. DATE OF BIRTH | 6. AGE | 7. IF UNDER 1 YEAR | |
| M | B | MONTH DAY YEAR | 85 | IF UNDER 24 HRS | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) | | 7b. CITIZEN OF WHAT COUNTRY? | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | |
| N. CAROLINA | | USA | | 9. BALTIMORE CITY OR COUNTY OF DEATH | |
| 10. CITY OR TOWN OF DEATH | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | |
| Baltimore | | S. BALTO GEN HOSP | | RETIRED | |
| 13a. STATE | | 13b. COUNTY | | 13c. CITY OR TOWN | |
| MD | | BALTO | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 14. FATHER'S NAME | | 15. MOTHER'S MAIDEN NAME | | 13e. STREET ADDRESS | |
| FIRST MIDDLE LAST | | FIRST MIDDLE LAST | | 3312 TATE ST. | |
| FRANK JOHNSON | | ALICE WHITESIDE | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) | | 16b. SOCIAL SECURITY NO. | | 17. INFORMANT ADDRESS | |
| NO | | 217-05-6957 | | Etta Johnson 3312 Tate St. | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| PART 1. DEATH WAS CAUSED BY: | | | | | |
| IMMEDIATE CAUSE (a) RESPIRATORY FAILURE | | | | | |
| 1539 DUE TO, OR AS A CONSEQUENCE OF | | | | 5 YRS | |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. | | | | | |
| (b) METASTATIC COLON CARCINOMA | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF | | | | | |
| (c) | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? | |
| | | | | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | |
| | | P.M. 19 | | | |
| 21d. INJURY OCCURRED | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION | |
| WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | | | STREET CITY OR TOWN COUNTY STATE | |
| 21g. I certify that (a) (this hospital) attended the deceased from 2/5 19 82, to 2/10 19 82, that (b) (we) last saw the deceased alive on 2/10 19 82, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (c) (we) (did not) view the body after death. | | | | | |
| 22a. SIGNATURE | | DEGREE | | 22c. DATE SIGNED | |
| C. ZIGEL | | | | 2/10/82 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) | | 22e. ADDRESS | | | |
| C. ZIGEL | | 3001 S. HANOVER ST | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) | | 23b. DATE | | 23c. NAME OF CEMETERY OR CREMATORY | |
| Burial | | 2/13/82 | | Mt. Calvary Cem. | |
| 23d. LOCATION | | 23e. CITY OR TOWN | | 23f. COUNTY | |
| Baltimore | | Co. | | MD | |
| 24. FUNERAL DIRECTOR | | 25a. DATE REC'D. BY REGISTRAR | | 25b. REGISTRAR'S SIGNATURE | |
| Wm. C. March F/H | | FEB 11 1982 | | Name | |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the registrars, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

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| STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH | | | | | | | | | | 8 2 0 3 8 7 9 | |
|---|--|--|--|---|--|---|--|--|--|--|--|
| 1. FOR
STATE
REGISTRAR | | REG. NO. | | | | | | | | | |
| 1. DECEASED NAME
(TYPE OR PRINT)
JOSEPH R. JOHNSON | | | | | | 2a. DATE OF DEATH
MONTH DAY YEAR
2 16 82 | | 2b. HOUR
5:10 AM | | | |
| 3. SEX
MALE | | 4. RACE
WHITE | | 5. DATE OF BIRTH
MONTH DAY YEAR
2 23 18 | | 6. AGE (IN YEARS LAST BIRTHDAY)
63 YRS | | 7. IF UNDER 1 YEAR
MONTHS DAYS
IF UNDER 24 HRS
HOURS MIN. | | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
MARYLAND | | 7b. CITIZEN OF WHAT COUNTRY?
U.S.A. | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
BALTIMORE, CITY MD. | | | | | |
| 10. CITY OR TOWN OF DEATH
BALTIMORE | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
VAMC, 3900 LOCH RAVEN BLVD. | | | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
Stone Mason | | 12b. KIND OF BUSINESS OR INDUSTRY | | | |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)
STATE
MARYLAND | | 13b. COUNTY | | 13c. CITY OR TOWN
Baltimore | | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS
1038 Bristol Place | | | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
William Earnest Johnson | | | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
Catherine S. Neels | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
YES | | 16b. SOCIAL SECURITY NO.
(IF YES, GIVE WAR OR DATES)
WWII | | 17. INFORMANT ADDRESS
Lillian Johnson 1038 Bristol Place | | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART 1. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>cardio pulmonary arrest</u>
1629
DUE TO, OR AS A CONSEQUENCE OF:
(b) <u>bronchogenic squamous cell ca. of</u>
DUE TO, OR AS A CONSEQUENCE OF <u>right upper lobe</u>
(c) _____
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
4 months | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | | | |
| 21d. INJURY OCCURRED
WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | | | 21e. PLACE OF INJURY
(AT HOME STREET FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | | | |
| 22a. I certify that XX (this hospital) attended the deceased from <u>2-11</u> , 19 <u>82</u> , to <u>2-16</u> , 19 <u>82</u> , that (X) (we) lost saw the deceased alive on <u>2-16</u> , 19 <u>82</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (X) (we) (did) (not) view the body after death. | | | | | | | | | | | |
| 22b. SIGNATURE
<i>Robert Barthel</i> | | | | DEGREE
MD | | | | ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> | | 22c. DATE SIGNED
2/16/82 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
Robert Barthel M.D. | | | | 22e. ADDRESS
3900 LOCH RAVEN BLVD. BALTO. MD 21218 | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)
Burial | | 23b. DATE
2/18/82 | | 23c. NAME OF CEMETERY OR CREMATORY
Cedar Hill Cemetery Brooklyn | | | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
A.A. Md. | | | |
| 24. FUNERAL DIRECTOR
NAME Balto Md. 21225
George J. Gonce 4001 Ritchie Hwy | | | | 25a. DATE REC'D. BY REGISTRAR
FEB 19 1982 | | 25b. REGISTRAR'S SIGNATURE
<i>Frances J. Barthel</i> | | | | | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

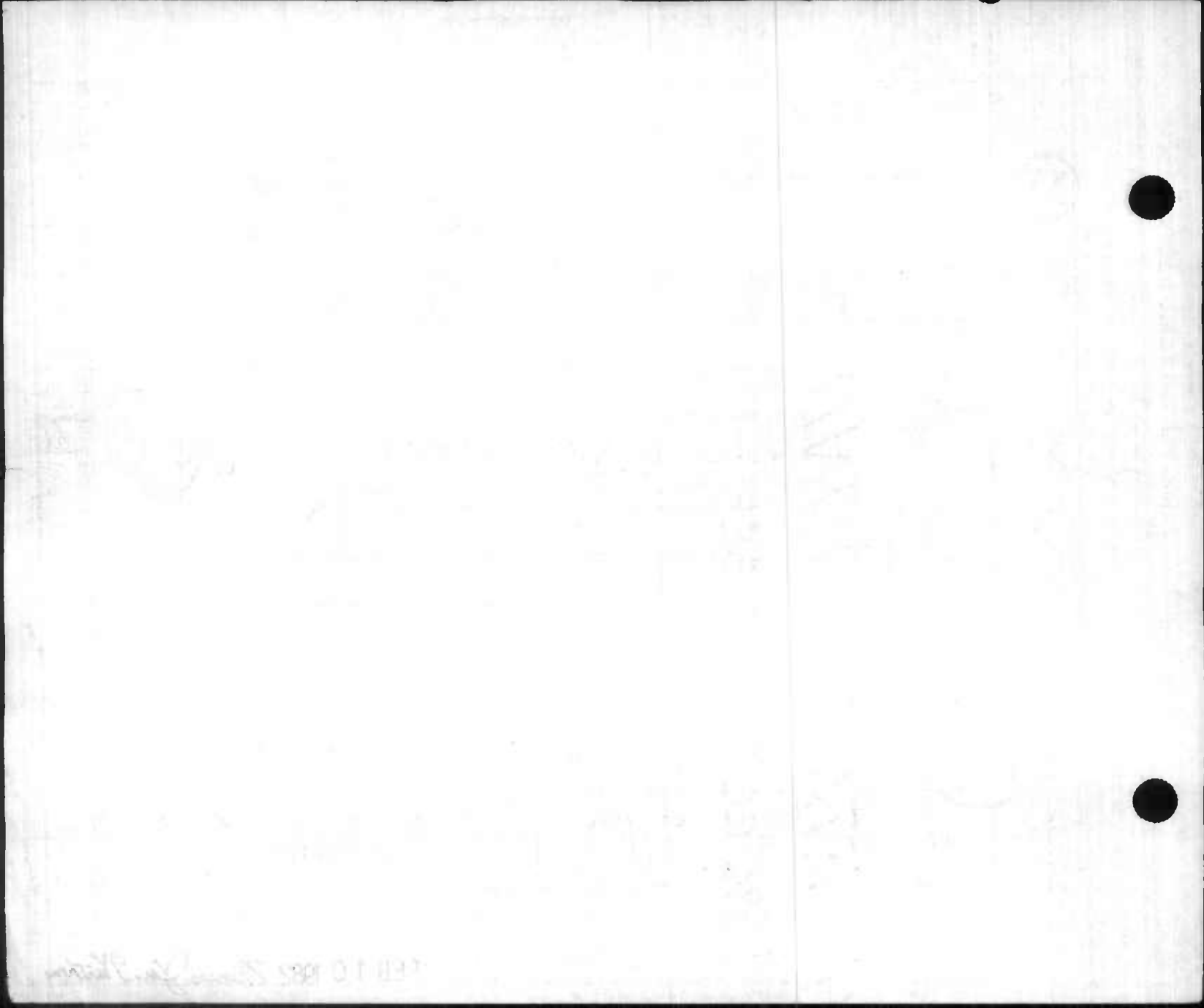
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 2 0 3 8 8 0

REG. NO.

| | | | | | | | | | | |
|--|--|--|---|--|---|--|--|---|--|--|
| 1 DECEASED NAME
(TYPE OR PRINT)
JUNIOUS
FIRST MIDDLE LAST | | | 2a DATE OF DEATH
MONTH DAY YEAR
FEBRUARY 4, 1982 | | | 2b HOUR
11:15 A.M. | | | | |
| 3 SEX
Male | | 4 RACE
Black | | 5 DATE OF BIRTH
MONTH DAY YEAR
12 5 '95 | | 6 AGE (IN YEARS LAST BIRTHDAY)
86
YRS. | | IF UNDER 1 YEAR
MONTHS DAYS
IF UNDER 24 HRS.
HOURS MIN. | | |
| 7a BIRTHPLACE (STATE OR FOREIGN COUNTRY)
VA | | 7b CITIZEN OF WHAT COUNTRY?
USA | | 8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9 BALTIMORE CITY OR COUNTY OF DEATH
Baltimore City MD. | | | | |
| 10 CITY OR TOWN OF DEATH
Baltimore | | 11 NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
Church Home & Hospital | | | | 12a USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE) | | 12b KIND OF BUSINESS OR INDUSTRY | | |
| 13a STATE
MD | | | 13b COUNTY | | 13c CITY OR TOWN
Baltimore | | 13d INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e STREET ADDRESS
315 S. Ballou Ct. | |
| 14 FATHER'S NAME
FIRST MIDDLE LAST
- | | | 15 MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
Pearl | | | | | | | |
| 16a WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
No | | | 16b SOCIAL SECURITY NO.
226-12-6111 | | 17 INFORMANT ADDRESS
Walter Artis 807 N. Montford Ave. | | | | | |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART 1. DEATH WAS CAUSED BY
IMMEDIATE CAUSE (a) <u>CARDIORESPIRATORY ARREST</u>
1991
DUE TO, OR AS A CONSEQUENCE OF
(b) <u>METASTATIC CARCINOMA OF LIVER</u>
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO, OR AS A CONSEQUENCE OF
(c) | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) | | | | | | | | | | |
| 19a DATE OF OPERATION | | | 19b CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | |
| 21a ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER NOTIFY MEDICAL EXAMINER) | | | 21b TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1B, PART 1 OR PART 2) | | | | | |
| 21d INJURY OCCURRED
WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | | 21e PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f LOCATION
STREET CITY OR TOWN COUNTY STATE | | | | | |
| 22a I certify that (I) (this hospital) attended the deceased from <u>JANUARY 8</u> , 19 <u>82</u> , to <u>FEBRUARY 4</u> , 19 <u>82</u> , that (I) (we) last saw the deceased alive on <u>FEBRUARY 4</u> , 19 <u>82</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | | |
| 22b SIGNATURE
T. Kawaja | | | DEGREE | | | ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> | | 22c DATE SIGNED
2.4.82 | | |
| 22d PHYSICIAN'S NAME (TYPE OR PRINT)
T. KAWAJA, M.D. | | | 22e ADDRESS
CHURCH HOSPITAL CORPORATION
100 NORTH BROADWAY, BALTIMORE, MD 21231 | | | | | | | |
| 23a BURIAL, CREMATION, REMOVAL
(SPECIFY)
Burial | | | 23b DATE
2/12/82 | | 23c NAME OF CEMETERY OR CREMATORY
Mt. Calvary Cem. | | 23d LOCATION
CITY OR TOWN COUNTY STATE
Baltimore Co. MD | | | |
| 24 FUNERAL DIRECTOR
NAME
Wm. C. March F/H 1101 E. North Ave. | | | | | 25a DATE REC'D. BY REGISTRAR
FEB 10 1982 | | 25b REGISTRAR'S SIGNATURE
Frances Jean Nathan | | | |



TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM "PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 24 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

FOR
1- STATE
REGISTRAR

1. DECEASED NAME

FIRST

MIDDLE

LAST

(TYPE OR PRINT)

MARY

L.

JOHNSON

2a. DATE KNOWN
OF
DEATH ESTI-
MATED
☒ MONTH DAY YEAR
☐ 2 5 1982

2b. HOUR

M

3. SEX

female

4. RACE

negro

5. DATE OF BIRTH

 MONTH DAY YEAR
 8 16 41

6. AGE (IN YEARS)

 LAST BIRTHDAY
 40 YRS.

IF UNDER 1 YR.

MONTHS DAYS HOURS MIN

IF UNDER 24 HRS.

7c. DATE
PRONOUNCED
DEAD
 MONTH DAY YEAR
 2 5 1982

2d. HOUR

 6:17
 P M
7a. BIRTHPLACE (STATE OR
FOREIGN COUNTRY)

S.C.

7b. CITIZEN OF WHAT COUNTRY?

USA

 8. MARRIED ☒ NEVER MARRIED ☐
 WIDOWED ☐ DIVORCED ☐

9. BALTIMORE CITY OR COUNTY OF DEATH

Baltimore City

MD.

10. CITY OR TOWN OF DEATH

Baltimore

11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION

(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)

1821 N. Etting St.

12a. USUAL OCCUPATION (TYPE OF WORK
FOR MOST OF WORKING LIFE)

Disabled

12b. KIND OF BUSINESS
OR INDUSTRY

USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

13a. STATE

Md

13b. COUNTY

13c. CITY OR TOWN

Balto

13d. INSIDE CITY LIMITS?

 YES ☒ NO ☐

13e. STREET ADDRESS

1821 N. Etting Street

14. FATHER'S NAME

John

MIDDLE

H. Brown

LAST

15. MOTHER'S MAIDEN NAME

Flora

MIDDLE

LAST

Tuck

16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO, OR UNKNOWN)

No

16b. SOCIAL SECURITY NO.
(IF YES, GIVE WAR OR DATES)

212 36 5254

17. INFORMANT

ADDRESS

 John H. Brown 851 George St. Box 212
 Apt 10F.

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART 1 DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a)

Hypertensive cardiovascular disease

DUE TO, OR AS A CONSEQUENCE OF

 4029
 Conditions, if any, which
 gave rise to immediate
 cause (a) stating the under-
 lying cause last.

(b)

DUE TO, OR AS A CONSEQUENCE OF

(c)

APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATH

PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)

19a. DATE OF OPERATION

19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?

20. AUTOPSY?

YES ☐ NO ☒

21a. EXTERNAL CAUSE WAS

 UNDERLYING ☐ OR
 CONTRIBUTING ☐ CAUSE OF DEATH

 21b. TIME OF INJURY
 HOUR A.M. MONTH DAY YEAR
 P.M. 19

21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)

21d. INJURY OCCURRED

 WHILE ☐ NOT WHILE ☐
 AT WORK AT WORK
21e. PLACE OF INJURY (AT HOME,
STREET, FACTORY, FARM, ETC.)

21f. LOCATION

STREET

CITY OR TOWN

COUNTY

STATE

 22a. I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☐, and in my opinion
 death resulted from: Natural causes ☒, Accident ☐, Suicide ☐, Homicide ☐, Undetermined manner ☐.
ACTUAL
SIGNATURE

TITLE (SPECIFY)

M.D. Assistant MEDICAL EXAMINER

DATE
SIGNED 2-6-82EXAMINER'S NAME
(TYPE OR PRINT)

Ann M. Dixon, M.D.

ADDRESS 111 Penn St.

23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)

Burial

23b. DATE

2-10-82

23c. NAME OF CEMETERY OR CREMATORY

Mt. Auburn Cem.

23d. LOCATION

Baltimore

COUNTY

STATE

Md.

24. FUNERAL DIRECTOR
NAME

Brown/Thompson F.H. 1913 W. Baltimore St.

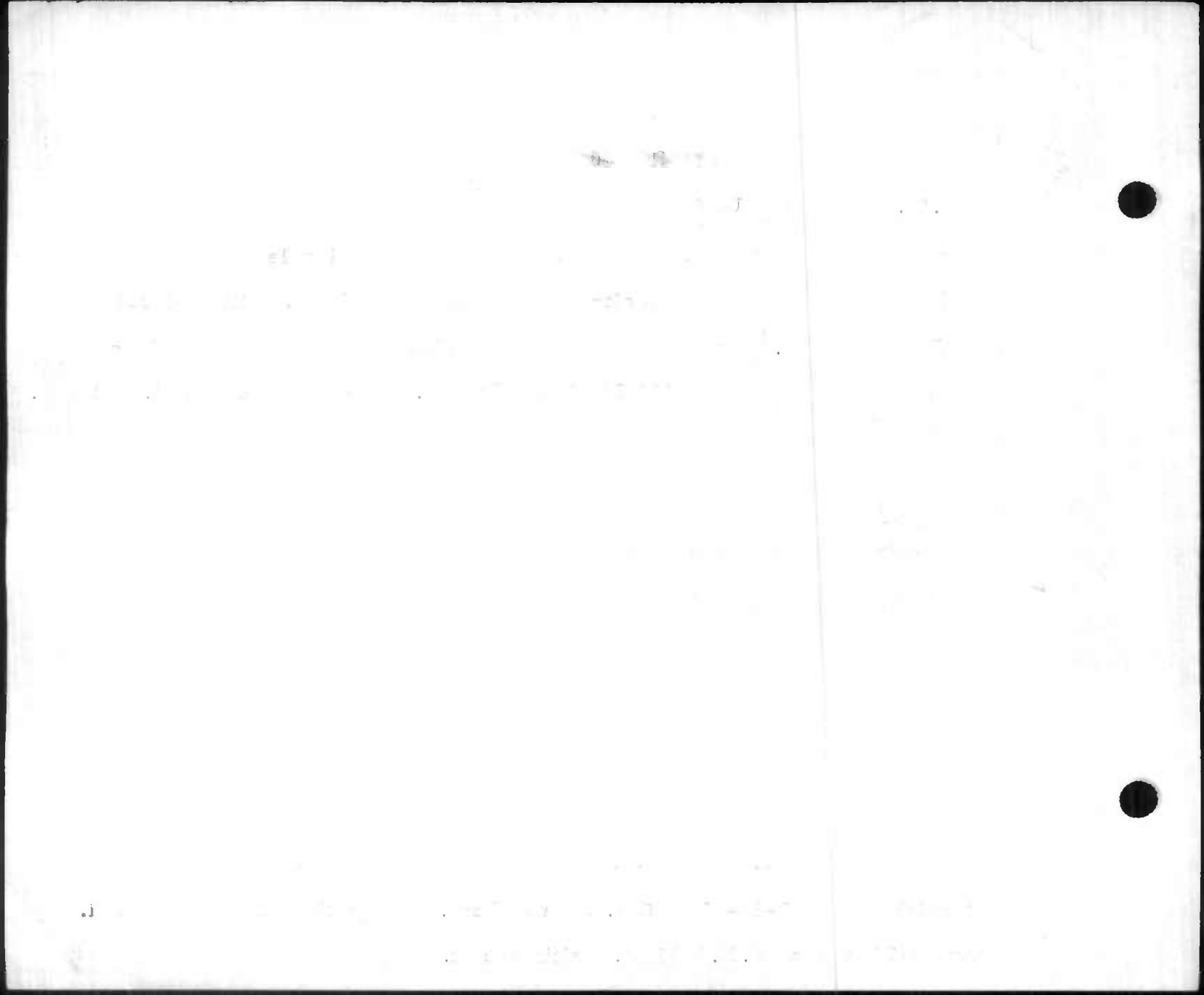
ADDRESS

25a. DATE REC'D. BY REGISTRAR

FEB 8 1982

25b. REGISTRAR'S SIGNATURE





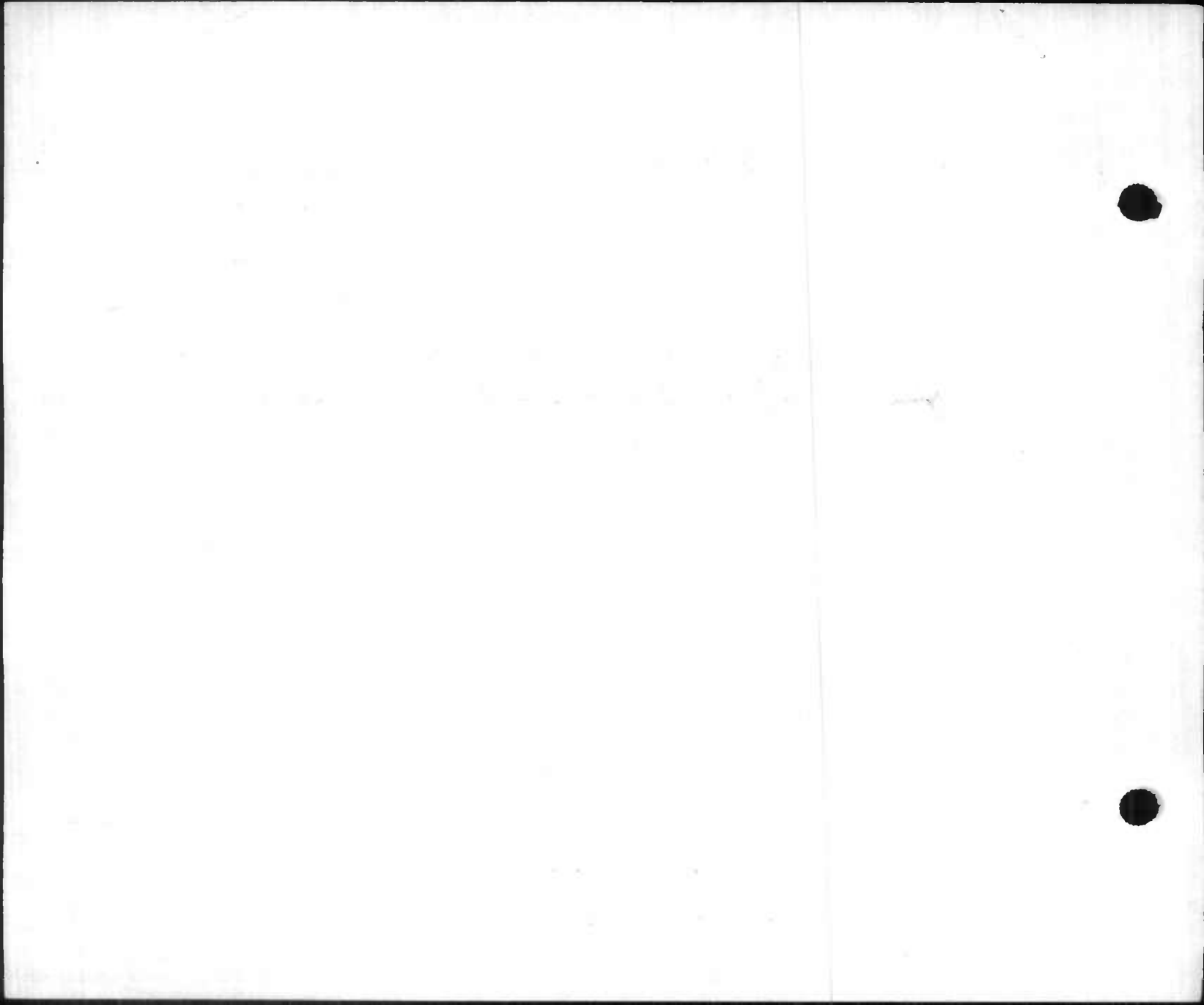
TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITH THE FILES AFTER DEATH. WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

FOR
1- STATE
REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

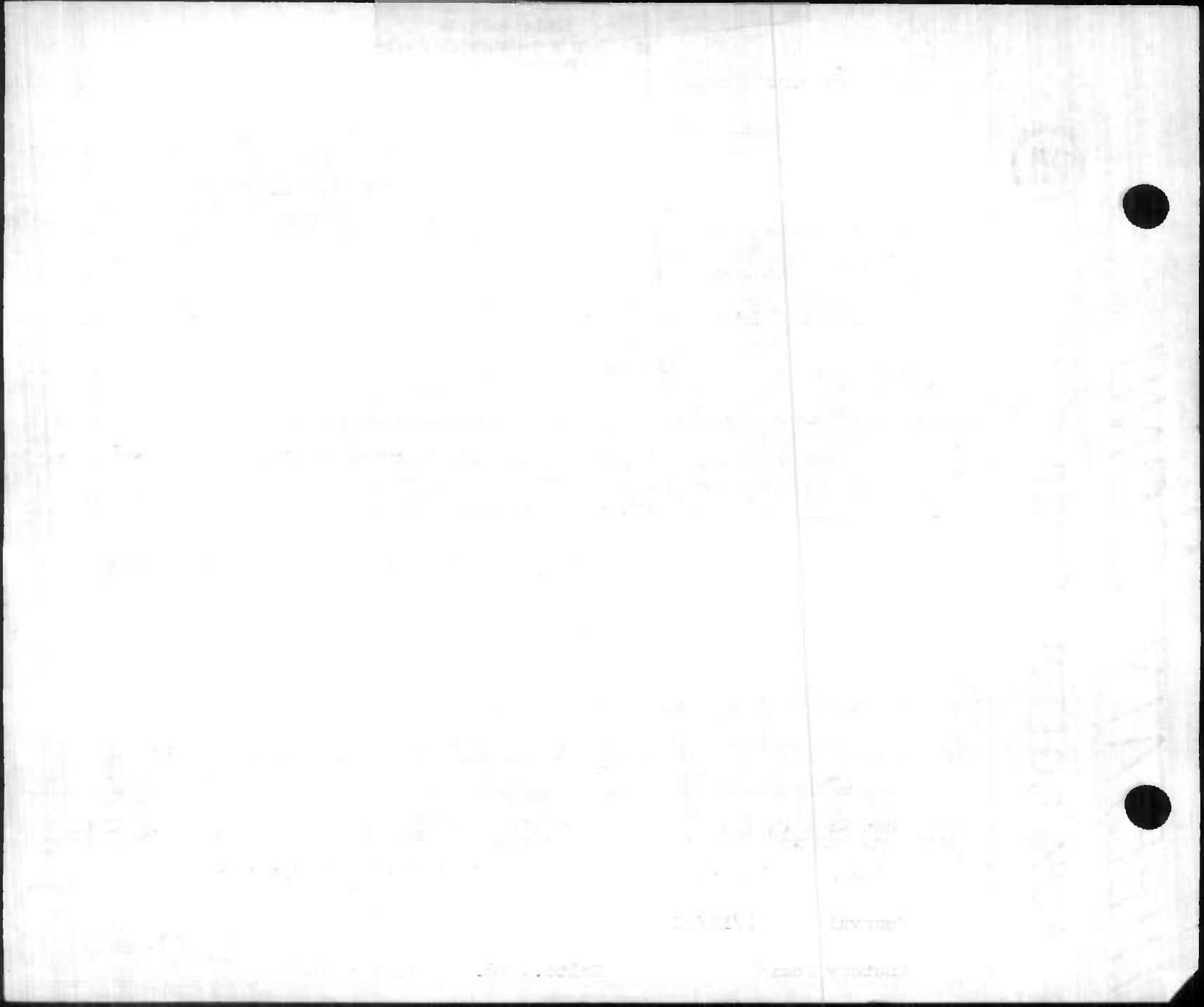
| | | | | | | | |
|--|------------------|--|---|---|--|---|---|
| 1. DECEASED NAME
(TYPE OR PRINT)
FIRST MIDDLE LAST
Samuel Johnson | | | 2a. DATE KNOWN OF DEATH
ESTIMATED
MONTH DAY YEAR
2 20 1982 | | | 2b. HOUR
M
7:14 M | |
| 3. SEX
Male | 4. RACE
Black | 5. DATE OF BIRTH
MONTH DAY YEAR
3 10 43 | 6. AGE (IN YEARS)
(LAST BIRTHDAY)
38 YRS. | IF UNDER 1 YR.
MONTHS DAYS | IF UNDER 24 HRS.
HOURS MIN. | 2c. DATE PRONOUNCED DEAD
MONTH DAY YEAR
2 21 1982 | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
Baltimore, Md. | | 7b. CITIZEN OF WHAT COUNTRY?
U.S.A. | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
Baltimore City, MD. | |
| 10. CITY OR TOWN OF DEATH
Baltimore | | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
567 Dolphin Street | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)
JANITOR | | 12b. KIND OF BUSINESS OR INDUSTRY
Housewife |
| 13a. STATE
Md. | | 13b. COUNTY | 13c. CITY OR TOWN
BALTO | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | 13e. STREET ADDRESS
567 Dolphin ST. | | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
Samuel E. Johnson | | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
Daisy Adams | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
Yes | | 16b. SOCIAL SECURITY NO.
6/4/61 | | 17. INFORMANT ADDRESS
214 40-6636 Samuel E. Johnson 115 Chestnut | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I DEATH WAS CAUSED BY:
7803 IMMEDIATE CAUSE (a) Seizure Disorder
Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.
(b) _____
(c) _____
DUE TO, OR AS A CONSEQUENCE OF
DUE TO, OR AS A CONSEQUENCE OF
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | | | | | | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | | | | | 20. AUTOPSY?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |
| 21a. EXTERNAL CAUSE WAS
UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2) | | | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK AT WORK | | 21e. PLACE OF INJURY (AT HOME STREET, FACTORY, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | |
| 22a. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> . | | | | | | | |
| ACTUAL SIGNATURE
Virginia L. Dolan | | TITLE (SPECIFY)
M.D. Assistant | | | DATE SIGNED
2-21-82 | | |
| EXAMINER'S NAME
(TYPE OR PRINT)
Virginia L. Dolan, M.D. | | ADDRESS
111 Penn Street | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)
Burial | | 23b. DATE
2-24-82 | 23c. NAME OF CEMETERY OR CREMATORY
King Mem PK. | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
Randalls Town, Md. | | |
| 24. FUNERAL DIRECTOR
NAME ADDRESS
JAS. A. MORTON & SONS 1701 WARENS | | | 25a. DATE REC'D. BY REGISTRAR
FEB 23 1982 | | 25b. REGISTRAR'S SIGNATURE
Thomas J. [Signature] | | |



TO HOSPITAL OR ATTENDING PHYSICIAN. The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

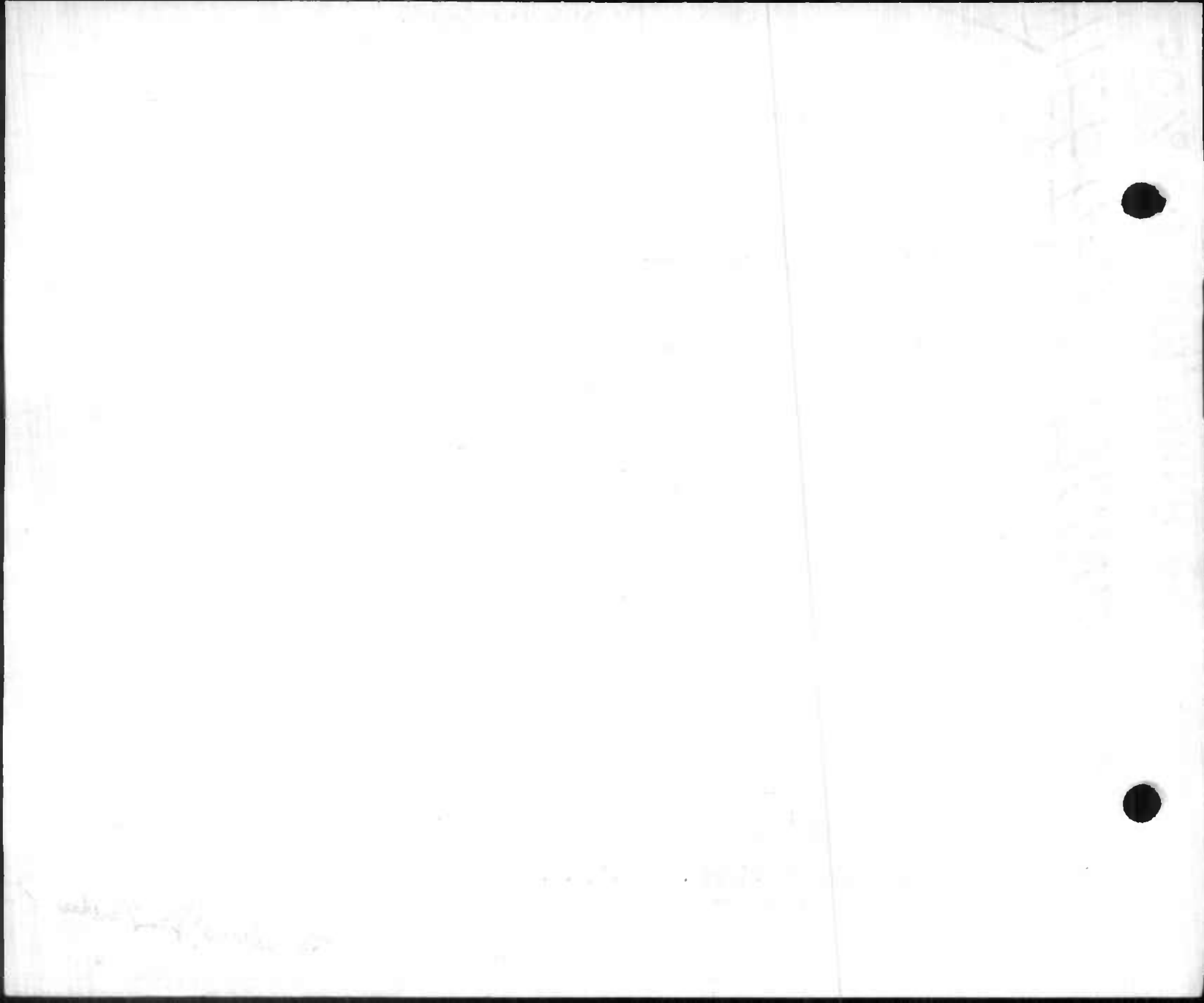
TO FUNERAL DIRECTOR. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH | | | | | | | | | | 8 2 0 3 8 8 3 | | | |
|--|--|---|--|--|--|--|--|--|--|--|--|--------------------------------|--|
| 1. FOR
STATE
REGISTRAR | | REG. NO. | | | | | | | | | | | |
| 1. DECEASED NAME (TYPE OR PRINT)
Shannon | | FIRST
Shannon | | MIDDLE | | LAST
Johnson | | 2b. DATE OF DEATH
MONTH DAY YEAR
2 12 82 | | | | 2b. HOUR
1:29 ^{PM} | |
| 3. SEX
Female | | 4. RACE
Black | | 5. DATE OF BIRTH
MONTH DAY YEAR | | | | 6. AGE (IN YEARS LAST BIRTHDAY)
1 day YRS. | | IF UNDER 1 YEAR
MONTHS DAYS | | IF UNDER 24 HRS.
HOURS MIN. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
Md | | 7b. CITIZEN OF WHAT COUNTRY?
U.S.A | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | | | 9. BALTIMORE CITY OR COUNTY OF DEATH
Baltimore City MD | | | | | |
| 10. CITY OR TOWN OF DEATH
Baltimore | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
Univ of Maryland | | | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE) | | | | 12b. KIND OF BUSINESS OR INDUSTRY | | | |
| 13a. STATE
Md | | 13b. CITY OR TOWN
Baltimore | | 13c. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS
7911 Myers Dr | | | | | | | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
Turrone | | | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
Beverly Johnson | | | | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN) | | | | | |
| 16b. SOCIAL SECURITY NO. | | | | 17. INFORMANT ADDRESS | | | | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART 1. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>Respiratory Arrest - Cardiac Arrest</u>
7651
DUE TO, OR AS A CONSEQUENCE OF
(b) <u>Sepsis</u>
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(c) <u>Prematurity</u>
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
<u>20</u> 1 hour
20 hours | | | | | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) | | | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | | | |
| 21d. INJURY OCCURRED
WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>2/11</u> 19 <u>82</u> , to <u>2/12</u> 19 <u>82</u> , that (I) (we) last saw the deceased alive on <u>2/12</u> 19 <u>82</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | | | | | |
| 22b. SIGNATURE
Dorothy Bules MD | | | | | | | | DEGREE
MD | | ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> | | 22c. DATE SIGNED
2/12/82 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
Dorothy Bules MD | | | | | | | | 22e. ADDRESS
5407 Tona Dr Columbia | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)
Removal | | | | 23b. DATE
2/18/82 | | 23c. NAME OF CEMETERY OR CREMATORY | | | | 23d. LOCATION
CITY OR TOWN COUNTY STATE | | | |
| 24. FUNERAL DIRECTOR
NAME
Anatomy Board | | | | | | | | ADDRESS
Balto., Md. | | 25a. DATE REC'D. BY REGISTRAR
FEB 25 1982 | | 25b. REGISTRAR'S SIGNATURE | |



TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 IN YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 24 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

| STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH | | | | | | | | | | REG. NO. 3 2 0 3 8 8 4 | | | |
|--|--|------------------|--|--|--|---|--|---|--|---|--|-----------------------|--|
| 1. DECEASED NAME
(TYPE OR PRINT) FIRST MIDDLE LAST
SUSIE R. JOHNSON | | | | | | | | | | 2a. DATE KNOWN OF DEATH
MONTH DAY YEAR
2-4-82 19 | | 2b. HOUR
M
5:50 | |
| 3. SEX
female | | 4. RACE
black | | 5. DATE OF BIRTH
MONTH DAY YEAR
3 26 1899 | | 6. AGE (IN YEARS)
LAST BIRTHDAY
82 YRS. | | IF UNDER 1 YR.
MONTHS DAYS HOURS MIN | | 7c. DATE PRONOUNCED DEAD
MONTH DAY YEAR
2-4-82 19 | | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
MD | | | | 7b. CITIZEN OF WHAT COUNTRY?
USA | | | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | | | | |
| 9. BALTIMORE CITY OR COUNTY OF DEATH
Baltimore City MD | | | | 10. CITY OR TOWN OF DEATH
Baltimore | | | | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
3125 Oakford Avenue | | | | | |
| 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)
Baltimore | | | | 12b. KIND OF BUSINESS OR INDUSTRY | | | | 13a. STATE
MD | | | | | |
| 13b. COUNTY | | | | 13c. CITY OR TOWN
Baltimore | | | | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | | | |
| 13e. STREET ADDRESS
1803 Kavanaugh St. | | | | 14. FATHER'S NAME
FIRST MIDDLE LAST
Ellwood Richardson | | | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
Laura V. Hawkins | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO, OR UNKNOWN)
No | | | | 16b. SOCIAL SECURITY NO.
(IF YES, GIVE WAR OR DATES)
N/A | | | | 17. INFORMANT ADDRESS
Marie Johnson 3125 Oakford Ave. | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I DEATH WAS CAUSED BY:
4292 IMMEDIATE CAUSE (a) <u>Arteriosclerotic cardiovascular disease</u>
DUE TO, OR AS A CONSEQUENCE OF
(b) _____
DUE TO, OR AS A CONSEQUENCE OF
(c) _____
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a): | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | | |
| 19a. DATE OF OPERATION | | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | | | | 20. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | |
| 21a. EXTERNAL CAUSE WAS
UNDERLYING <input type="checkbox"/> OR
CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH | | | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) | | | | | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK AT WORK | | | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) | | | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | | | |
| 22a. I certify that I took charge of the remains described above, held on
death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>
Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion | | | | | | | | | | | | | |
| ACTUAL SIGNATURE
Houye Bechale | | | | TITLE (SPECIFY)
M.D. Assistant MEDICAL EXAMINER | | | | DATE SIGNED
2-5-82 | | | | | |
| EXAMINER'S NAME
(TYPE OR PRINT)
Margarita A. Koroll, M.D. | | | | ADDRESS
111 Penn Street | | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)
Burial | | | | 23b. DATE
2/10/82 | | | | 23c. NAME OF CEMETERY OR CREMATORY
King Mem. Park | | | | | |
| 23d. LOCATION
CITY OR TOWN
Baltimore | | | | 23e. DATE REC'D. BY REG. CLERK
FEB 9 1982 | | | | 23f. SIGNATURE
John N. [Signature] | | | | | |
| 24. FUNERAL DIRECTOR
NAME
Wm. C. March F/H | | | | ADDRESS
1101 E. North Ave. | | | | | | | | | |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed with the death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

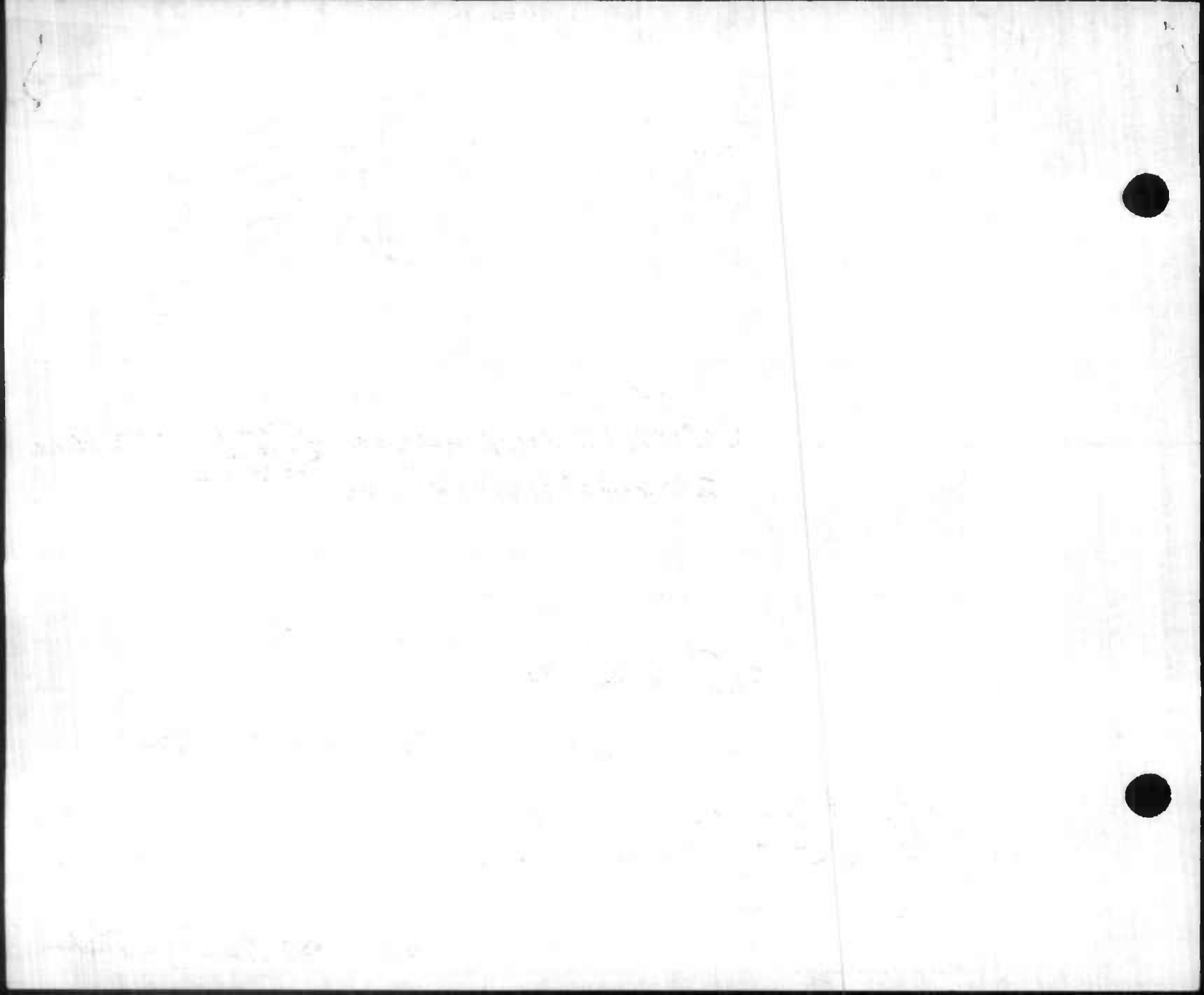
IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at the

1. FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

8 2 0 3 8 8 5

| | | | | | |
|--|--|---|---|---|--|
| 1. DECEASED NAME
(TYPE OR PRINT)
FIRST MIDDLE LAST
Thomas B. Johnson | | | 2a. DATE OF DEATH
MONTH DAY YEAR
February 26, 1982 | | 2b. HOUR
M
AM |
| 3. SEX
Male | 4. RACE
Black | 5. DATE OF BIRTH
MONTH DAY YEAR
6 20 10 | | 6. AGE [IN YEARS LAST BIRTHDAY]
71 | IF UNDER 1 YEAR
MONTHS DAYS
IF UNDER 74 HRS.
HOURS MIN. |
| 7a. BIRTHPLACE
(STATE OR FOREIGN COUNTRY)
MD | 7b. CITIZEN OF WHAT COUNTRY?
USA | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
Baltimore City MD | |
| 10. CITY OR TOWN OF DEATH
Baltimore | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
4025 Park Heights Ave. | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE) | | 12b. KIND OF BUSINESS OR INDUSTRY |
| 13a. STATE
MD | | 13b. COUNTY | 13c. CITY OR TOWN
Baltimore | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | 13e. STREET ADDRESS
4025 Park Heights Ave. |
| 14. FATHER'S NAME
FIRST MIDDLE LAST | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
Marie Thornton | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)
Yes | | 16b. SOCIAL SECURITY NO.
215-09-1078 | 17. INFORMANT
ADDRESS
James Henderson 2602 Rosewood Ave. | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART 1. DEATH WAS CAUSED BY:
4360 Cerebral Vascular Accident - Brain Stem Anoxia
IMMEDIATE CAUSE (a) ESSENTIAL Hypertension
DUE TO, OR AS A CONSEQUENCE OF (b)
DUE TO, OR AS A CONSEQUENCE OF (c)
Approximate interval between onset and death: 72 Hrs | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a. | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
7:45 P.M. 2 26 1982 | | 21c. HOW INJURY OCCURRED (Enter nature of injury in item 18, PART 1 OR PART 2) | |
| 21d. INJURY OCCURRED
WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | |
| 22a. I certify that (I) (this hospital) attended the deceased from 12/21 19 81 to 2/26/ 19 82 , that (I) (we) last saw the deceased alive on 2/12 19 82 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | |
| 22b. SIGNATURE
Robert J. Williams | | DEGREE
MO | | 22c. DATES SIGNED
2/26/82 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
Robert J. Williams | | 22e. ADDRESS
4200 EDMONDSON AVE 22 | | | |
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)
Burial | 23b. DATE
3/3/82 | 23c. NAME OF CEMETERY OR CREMATORY
Md. Veteran Cem. | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
Crownsville MD | |
| 24. FUNERAL DIRECTOR
NAME ADDRESS
Wm. C. March F/H 1101 E. North Ave. | | 25a. DATE REC'D. BY REGISTRAR 25b. REGISTRAR'S SIGNATURE
MAR 1 1982 Frances Jean Thornton | | | |



TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, REASE
EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR.
PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES.
TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 24 HOURS
AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET,
BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

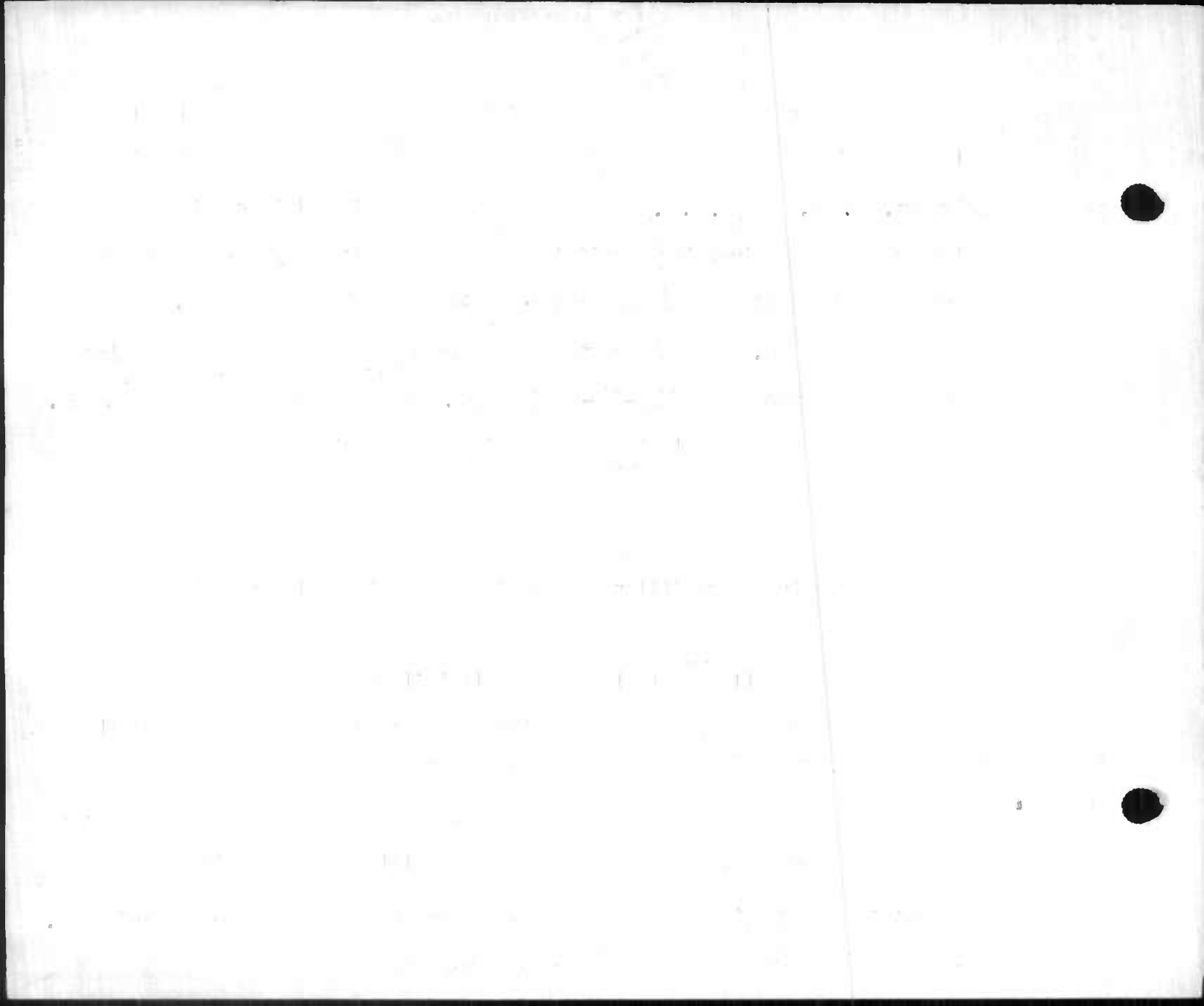
BP

DHMH - 17
(VR A15 ME (5))
15M 2/80

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | | | | | |
|---|--|--|--|---|--|---|--|------------------------------------|--|--|--|
| 1- FOR STATE REGISTRAR | | 2- DATE KNOWN OF DEATH | | 3- MONTH | | 4- DAY | | 5- YEAR | | 6- HOUR | |
| 1. DECEASED NAME (TYPE OR PRINT) | | 2a. DATE KNOWN OF DEATH | | 3- MONTH | | 4- DAY | | 5- YEAR | | 6- HOUR | |
| Howard Ray Johnston | | 2a. DATE KNOWN OF DEATH | | 3- MONTH | | 4- DAY | | 5- YEAR | | 6- HOUR | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) | | 7b. CITIZEN OF WHAT COUNTRY? | | 8. MARRIED | | 9. NEVER MARRIED | | 10. DIVORCED | | 11. BALTIMORE CITY OR COUNTY OF DEATH | |
| Ashe Co. N. C. | | U.S.A. | | MARRIED | | NEVER MARRIED | | DIVORCED | | Baltimore City, Md. | |
| 10. CITY OR TOWN OF DEATH | | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | | 12b. KIND OF BUSINESS OR INDUSTRY | | 13a. STATE | | 13b. COUNTY | |
| Baltimore | | University Hospital | | maintenance | | state | | Maryland | | Carroll | |
| 13a. STATE | | 13b. COUNTY | | 13c. CITY OR TOWN | | 13d. INSIDE CITY LIMITS? | | 13e. STREET ADDRESS | | 14. FATHER'S NAME | |
| Maryland | | Carroll | | Westminster | | YES | | 30 Locust St. | | James A. Johnston | |
| 14. FATHER'S NAME | | 15. MOTHER'S MAIDEN NAME | | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? | | 16b. SOCIAL SECURITY NO. | | 17. INFORMANT | | 18. CAUSE OF DEATH | |
| James A. Johnston | | Rose Gentry | | No | | 215-14-2993 | | Mrs. Robert Royer Hampstead, Md. | | Incised wounds of neck and wrist | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | | 20. AUTOPSY? | | 21a. EXTERNAL CAUSE WAS | | 21b. TIME OF INJURY | | 21c. HOW INJURY OCCURRED | |
| | | Congestive heart failure & Chronic obstructive pulmonary disease | | YES | | NO | | 11:30 AM | | self inflicted | |
| 21a. EXTERNAL CAUSE WAS | | 21b. TIME OF INJURY | | 21c. HOW INJURY OCCURRED | | 21d. INJURY OCCURRED | | 21e. PLACE OF INJURY | | 21f. LOCATION | |
| UNDERLYING | | 11:30 AM | | self inflicted | | WHILE AT WORK | | home | | 2139 Cape Horn Rd. Hampstead Carroll Md. | |
| 21d. INJURY OCCURRED | | 21e. PLACE OF INJURY | | 21f. LOCATION | | 21g. I certify that I took charge of the remains described above, held on | | 21h. Autopsy | | 21i. Inspection | |
| WHILE AT WORK | | home | | 2139 Cape Horn Rd. Hampstead Carroll Md. | | death resulted from | | Autopsy | | Inspection | |
| 21g. I certify that I took charge of the remains described above, held on | | 21h. Autopsy | | 21i. Inspection | | 21j. Inquiry | | 21k. and in my opinion | | 21l. TITLE (SPECIFY) | |
| 21h. Autopsy | | Inspection | | Inquiry | | and in my opinion | | TITLE (SPECIFY) | | M.D. Deputy Chief Medical Examiner | |
| 21i. Inspection | | Inquiry | | and in my opinion | | TITLE (SPECIFY) | | M.D. Deputy Chief Medical Examiner | | DATE SIGNED | |
| 21j. Inquiry | | and in my opinion | | TITLE (SPECIFY) | | M.D. Deputy Chief Medical Examiner | | DATE SIGNED | | 2/2/82 | |
| 21k. and in my opinion | | TITLE (SPECIFY) | | M.D. Deputy Chief Medical Examiner | | DATE SIGNED | | 2/2/82 | | 2/2/82 | |
| 21l. TITLE (SPECIFY) | | M.D. Deputy Chief Medical Examiner | | DATE SIGNED | | 2/2/82 | | 2/2/82 | | 2/2/82 | |
| 21m. EXAMINER'S NAME | | 21n. ADDRESS | | 21o. NAME OF CEMETERY OR CREMATORY | | 21p. LOCATION | | 21q. COUNTY | | 21r. STATE | |
| Thomas D. Smith, M.D. | | 111 Penn St. Balto., Md. | | Westminster Cemetery | | Westminster | | Carroll | | Md. | |
| 21p. LOCATION | | 21q. COUNTY | | 21r. STATE | | 21s. DATE REC'D. BY REGISTRAR | | 21t. REGISTRAR'S SIGNATURE | | 21u. DATE REC'D. BY REGISTRAR | |
| Westminster | | Carroll | | Md. | | FEB 5 1982 | | Name of Registrar | | FEB 5 1982 | |

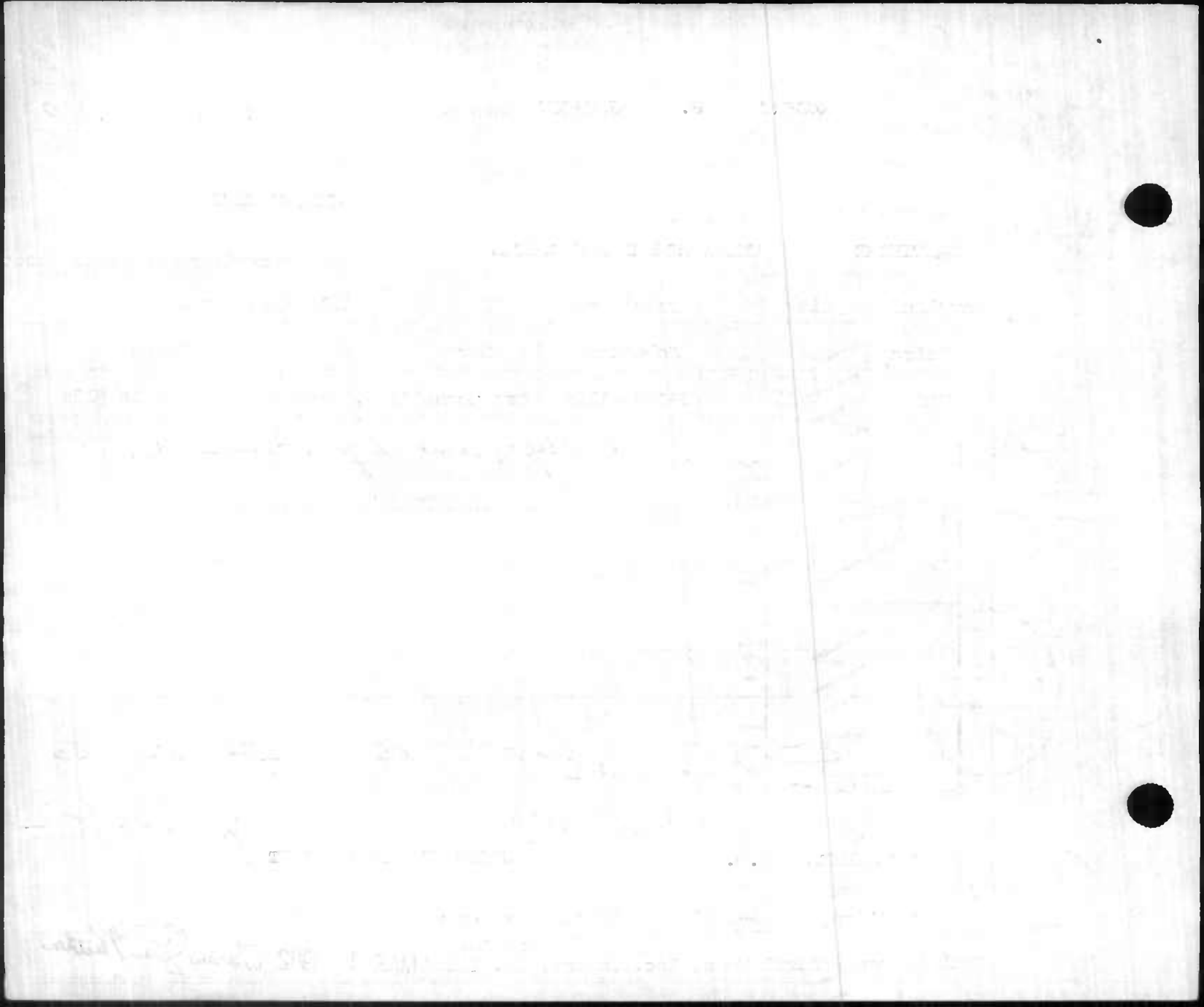


STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 2 0 3 8 8 7

REG. NO.

| | | | | | | | | | | | |
|--|--|---|--|---|--|---|--|--|--|--|--|
| 1. DECEASED NAME
(TYPE OR PRINT) | | FIRST
ROBERT | | MIDDLE
P. | | LAST
JOHNSTON | | 2a. DATE OF DEATH
MONTH DAY YEAR
2-26-82 | | 2b. HOUR
655 P.M. | |
| 3. SEX
Male | | 4. RACE
White | | 5. DATE OF BIRTH
MONTH DAY YEAR
July 5, 1924 | | 6. AGE (IN YEARS LAST BIRTHDAY)
57 | | IF UNDER 1 YEAR
MONTHS DAYS
YRS | | IF UNDER 24 HRS.
HOURS MIN.
MD | |
| 7a. BIRTHPLACE
(STATE OR FOREIGN COUNTRY)
West Virginia | | 7b. CITIZEN OF WHAT COUNTRY?
U. S. A. | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
BALTIMORE CITY | | | | | |
| 10. CITY OR TOWN OF DEATH
BALTIMORE | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
UNION MEMORIAL HOSPITAL | | | | | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
Field Supervisor | | 12b. KIND OF BUSINESS OR INDUSTRY
National Floor | |
| 13a. STATE
Maryland | | 13b. COUNTY
City | | 13c. CITY OR TOWN
Baltimore | | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS
3519 Ailsa Ave. | | | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
Peirce Johnston | | | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
Lura Young | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
YES | | 16b. SOCIAL SECURITY NO.
(IF YES, GIVE WAR OR DATES)
WWII | | 16c. SOCIAL SECURITY NO.
233-36-1724 | | 17. INFORMANT ADDRESS
Mrs Cornelia M. Raudenbush, Same As #13e | | | | | |
| 18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY
4100
IMMEDIATE CAUSE (a) Acute Myocardial Infarction
DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b) _____
DUE TO, OR AS A CONSEQUENCE OF
(c) _____
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
36 hrs | | | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: _____ | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1B, PART 1 OR PART 2) | | | | | | | |
| 21d. INJURY OCCURRED
WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 2/25 , 19 82 , to 2/26 , 19 82 , that (I) (we) last saw the deceased alive on 2/26 , 19 82 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death. | | | | | | | | | | | |
| 22b. SIGNATURE
Yael Yokel | | | | DEGREE
M.D. | | | | ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> | | 22c. DATE SIGNED
2/26/82 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
Yael Yokel | | | | 22e. ADDRESS
UNION MEMORIAL HOSPITAL | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)
Cremation | | 23b. DATE
3-1-82 | | 23c. NAME OF CEMETERY OR CREMATORY
Loudon Park Crematory | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
Baltimore, Maryland | | | | | |
| 24. FUNERAL DIRECTOR
NAME ADDRESS
Ruck Towson Funeral Home, Inc. Towson, Md. 21204 | | | | 25a. DATE REC'D. BY REGISTRAR
MAR 1 1982 | | 25b. REGISTRAR'S SIGNATURE
Frances Jean Nathan | | | | | |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. It must be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

item 8 #G567 5/4/82 ph

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO. 8 2 0 3 8 8 8

1- STATE REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST
Charles W Jones

2a. DATE OF DEATH MONTH DAY YEAR
2 4 82

2b. HOUR
10¹³ P M

3. SEX Male

4. RACE Black

5. DATE OF BIRTH MONTH DAY YEAR
1 3 44

6. AGE (IN YEARS LAST BIRTHDAY) YRS. MONTHS DAYS HOURS MIN.
38

7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Md

7b. CITIZEN OF WHAT COUNTRY? USA

8. MARRIED ☒ NEVER MARRIED ☐
WIDOWED ☐ DIVORCED ☐

9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City MD.

10. CITY OR TOWN OF DEATH Baltimore

11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
U of Md. Hospital

12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Truck Driver

12b. KIND OF BUSINESS OR INDUSTRY

13a. STATE Md

13b. COUNTY Balt City

13c. CITY OR TOWN Baltimore

13d. INSIDE CITY LIMITS? YES ☒ NO ☐

13e. STREET ADDRESS 5153 Frederick Rd

14. FATHER'S NAME FIRST MIDDLE LAST
Wesley Jones

15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST
Aurdrey Contee

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) Unknown

16b. SOCIAL SECURITY NO. 216-40-0396

17. INFORMANT ADDRESS
JEANETTE COLEMAN 5153 Frederick Rd

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART 1. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Cardiac Arrest
4232
DUE TO, OR AS A CONSEQUENCE OF (b) Myocardial Infarction
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last
DUE TO, OR AS A CONSEQUENCE OF (c)

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)
Chronic Renal Failure, Uremic Pericarditis

19a. DATE OF OPERATION 2/3/82

19b. CONDITION FOR WHICH OPERATION WAS PERFORMED Renstruck Pericarditis

20a. AUTOPSY? YES ☐ NO ☒

20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES ☐ NO ☐

21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR
P.M. 19

21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)

21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)

21f. LOCATION STREET CITY OR TOWN COUNTY STATE

22a. I certify that (I) (this hospital) attended the deceased from Feb 1, 19 82, to Feb 4, 19 82, that (I) (we) last saw the deceased alive on Feb 4, 19 82, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE Francis T. Ferraro MD

DEGREE Resident Physician

ATTENDING PHYSICIAN ☐ MEDICAL STAFF ☐ DIRECTOR ☐ PHYSICIAN ☐

22c. DATE SIGNED 2/4/82

22d. PHYSICIAN'S NAME (TYPE OR PRINT) FRANCIS T. FERRARO, MD

22e. ADDRESS Univ of Md Hospital

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial

23b. DATE 2-11-82

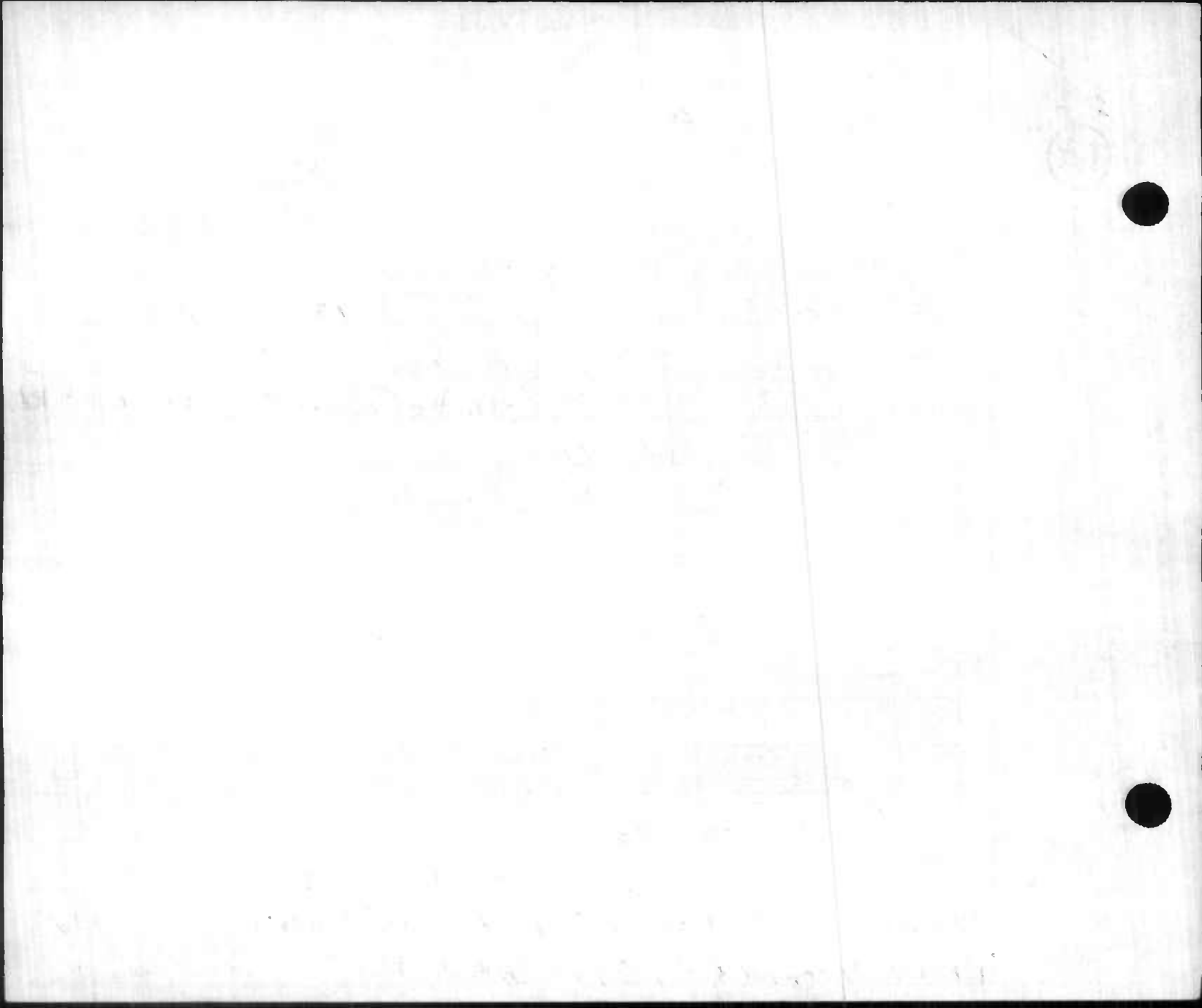
23c. NAME OF CEMETERY OR CREMATORY MT. RUSHMORE

23d. LOCATION Baltimore COUNTY MD

24. FUNERAL DIRECTOR NAME BROWN-THOMPSON F.H. ADDRESS 1913 W. BALTO SA

25a. DATE REC'D. BY REGISTRAR FEB 8 1982

25b. REGISTRAR'S SIGNATURE



TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILE. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP

DHMH - 17
(VR A15 ME (5))
15M 2/80

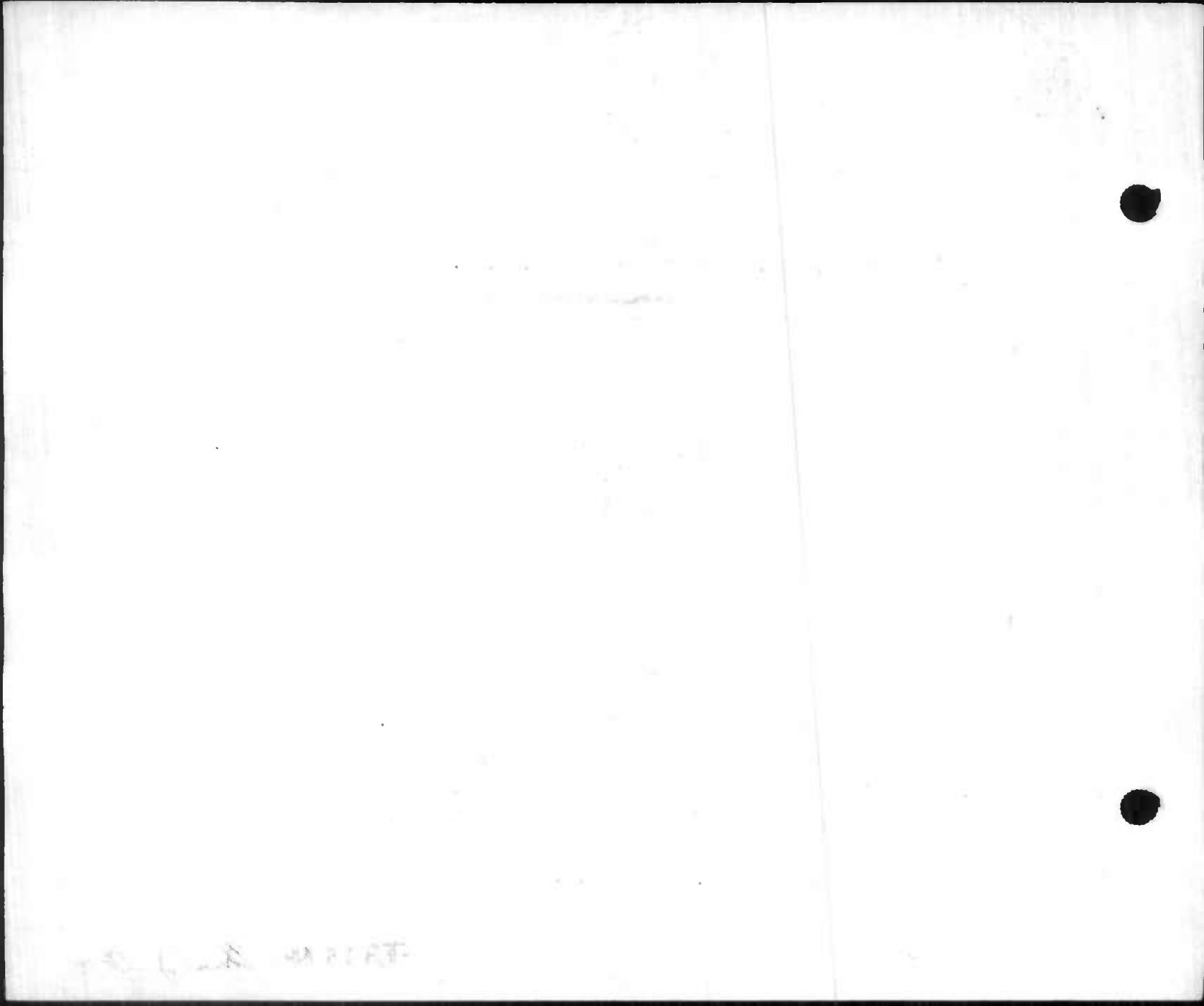
Item 1 G 564 2/17/82 GAB

FOR
1- STATE
REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | | | | | | | | | | | | |
|--|---------|------------------|---|----------------|------------------|---|--|--|---|--|--|--|--|----------------|--|--|--|--|
| 1. DECEASED NAME
(TYPE OR PRINT) | | | 2a. DATE KNOWN OF DEATH | | | 2b. DATE ESTIMATED | | | 2c. DATE PRONOUNCED DEAD | | | 2d. HOUR | | | | | | |
| Diane E. Jones (Coupling) | | | 2a. MONTH DAY YEAR
2-12-82 | | | 2b. MONTH DAY YEAR
2-12-82 | | | 2c. MONTH DAY YEAR
2-12-82 | | | 2d. HOUR
11:52 AM | | | | | | |
| 3. SEX | 4. RACE | 5. DATE OF BIRTH | 6. AGE (IN YEARS) | IF UNDER 1 YR. | IF UNDER 24 HRS. | 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) | | | 7b. CITIZEN OF WHAT COUNTRY? | | | 8. MARRIED | | | | | | |
| female | black | 12 29 45 | 36 YRS. | MONTHS | DAYS | MD | | | USA | | | WIDOWED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | | | | | |
| 10. CITY OR TOWN OF DEATH | | | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | | | 12b. KIND OF BUSINESS OR INDUSTRY | | | 9. BALTIMORE CITY OR COUNTY OF DEATH | | | | | | |
| Baltimore | | | Rm. 8 Drakes Motel 819 N. Pt. Rd. | | | | | | | | | Baltimore City MD | | | | | | |
| 13a. STATE | | | 13b. COUNTY | | | 13c. CITY OR TOWN | | | 13d. INSIDE CITY LIMITS? | | | 13e. STREET ADDRESS | | | | | | |
| MD | | | Harford | | | Edgewood | | | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | 803 St. George Ct. | | | | | | |
| 14. FATHER'S NAME | | | 15. MOTHER'S MAIDEN NAME | | | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? | | | 16b. SOCIAL SECURITY NO. | | | 17. INFORMANT ADDRESS | | | | | | |
| William Harris | | | Lillian Williams | | | No | | | N/A | | | 11617 Eastern A
Floyd S. Coupling Chase, MD | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I DEATH WAS CAUSED BY:
9630 IMMEDIATE CAUSE (a) <u>Strangulation</u>
DUE TO, OR AS A CONSEQUENCE OF
(b) _____
DUE TO, OR AS A CONSEQUENCE OF
(c) _____ | | | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | | | | | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a). | | | | | | | | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | | | | | | 20. AUTOPSY? | | | | | | | | | |
| | | | | | | | | | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | | | | | | | |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH | | | 21b. TIME OF INJURY | | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2) | | | | | | | | | | | | |
| | | | 2-12-82 | | | subject found strangled | | | | | | | | | | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK | | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) | | | 21f. LOCATION | | | | | | | | | | | | |
| | | | motel (Drakes) | | | 819 North Pt. Road Baltimore, Maryland | | | | | | | | | | | | |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input checked="" type="checkbox"/> Undetermined manner <input type="checkbox"/> . | | | | | | | | | | | | | | | | | | |
| ACTUAL SIGNATURE | | | TITLE (SPECIFY) | | | | | | DATE SIGNED | | | | | | | | | |
| Margarita A. Koroll | | | M.D. Assistant | | | | | | 2-13-82 | | | | | | | | | |
| EXAMINER'S NAME (TYPE OR PRINT) | | | ADDRESS | | | | | | | | | | | | | | | |
| Margarita A. Koroll, M.D. | | | 11 Penn Street | | | | | | | | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) | | | 23b. DATE | | | 23c. NAME OF CEMETERY OR CREMATORY | | | 23d. LOCATION (CITY OR TOWN) | | | COUNTRY | | STATE | | | | |
| Burial | | | 2/18/82 | | | Arbutus Mem. Park | | | Baltimore | | | Co. | | MD | | | | |
| 24. FUNERAL DIRECTOR | | | 25a. DATE REC'D. BY REGISTRAR | | | | | | 25b. REGISTRAR'S SIGNATURE | | | | | | | | | |
| Wm. C. March F/H | | | 1101 E. North Ave. | | | | | | FEB 16 1982 | | | | | Thane J. North | | | | |



STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 2 0 3 8 9 0

FOR
1. STATE
REGISTRAR

REG. NO.

| | | | | | |
|--|--|--|--|--|--|
| 1. DECEASED NAME
(TYPE OR PRINT)
FIRST MIDDLE LAST
ELVINA MAE JONES | | | 2a. DATE OF DEATH
MONTH DAY YEAR
2 5 82 | | 2b. HOUR
M
 |
| 3. SEX
Female | 4. RACE
White | 5. DATE OF BIRTH
MONTH DAY YEAR
9 21 83 | | 6. AGE (IN YEARS LAST BIRTHDAY)
98 YRS. | IF UNDER 1 YEAR
MONTHS DAYS
 |
| 7. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
Maryland | 7b. CITIZEN OF WHAT COUNTRY?
USA | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
Baltimore City MD. | |
| 10. CITY OR TOWN OF DEATH
Baltimore | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
22 S. Athol Avenue (German Home) | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
----- | | 12b. KIND OF BUSINESS OR INDUSTRY
Own Home |
| 13a. STATE
Md | | 13b. CITY OR TOWN
Baltimore | 13c. CITY OR TOWN
Woodlawn | 13d. INSIDE CITY LIMITS?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | 13e. STREET ADDRESS
3612 Milford Avenue |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
Joshua Jones | | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
Rebecca Perry | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
No | | 16b. SOCIAL SECURITY NO.
216-56-4575 | | 17. INFORMANT
ADDRESS
General German Aged Peoples Home
22 S. Athol Ave Baltimore, Md. 21229 | |
| 18. CAUSE OF DEATH Enter only one cause (a), (b), and (c).
PART 1. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Dehydration & malnutrition
4370
DUE TO, OR AS A CONSEQUENCE OF
(b) arteriosclerosis generalized sever.
DUE TO, OR AS A CONSEQUENCE OF
(c) Cerebral arteriosclerosis - atrophy
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a) | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | |
| 22a. I certify that (I) (this hospital) attended the deceased from June 19 80 to 5 Feb 19 82 , that (I) (we) last saw the deceased alive on 5 Feb 19 82 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | |
| 22b. SIGNATURE
William J. Bryson | | | | 22c. DATE SIGNED
8 Feb 82 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
William J. Bryson, M.D. | | | | 22e. ADDRESS
5772 Westview Mall Baltimore, Md. | |
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)
Burial | | 23b. DATE
2/9/82 | | 23c. NAME OF CEMETERY OR CREMATORY
Lorraine Park Cemetery | |
| 23d. LOCATION
CITY OR TOWN
Woodlawn | | 23e. COUNTY
Baltimore | | | |
| 24. FUNERAL DIRECTOR
NAME
Witzke, P.A. | | | | 25a. DATE RECEIVED BY
FEB 9 1982 | |
| 24. FUNERAL DIRECTOR
ADDRESS
1630 Edmondson Ave Catonsville, Md. 21228 | | | | 25b. SIGNATURE
James | |

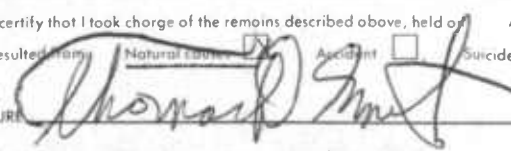

See

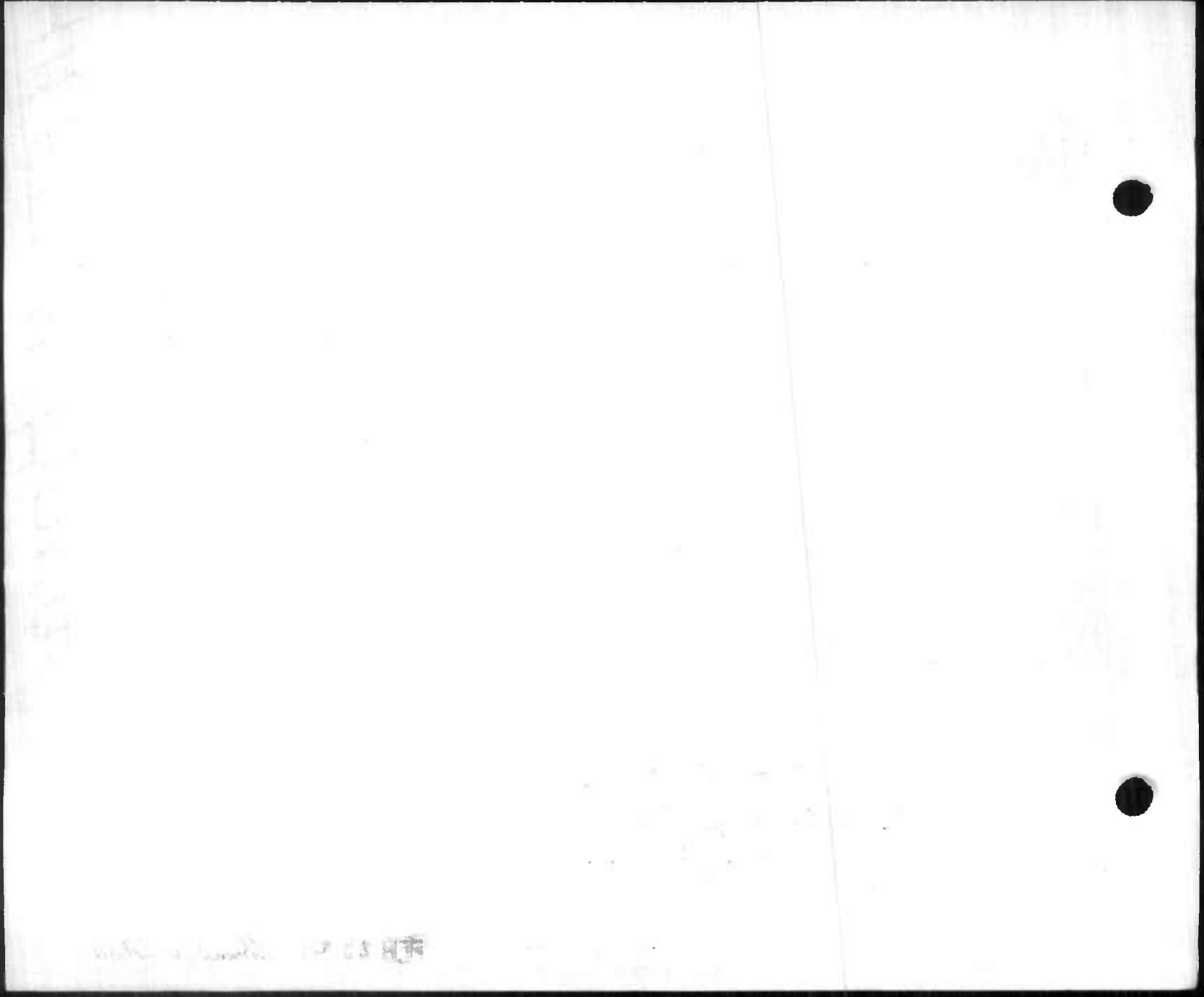
TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL HOME. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM "PM 3". RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITH THE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP
DHMH-17
(VR A15 ME (1))
15M 2/80

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

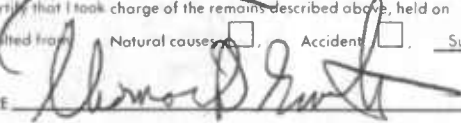

REG. NO.

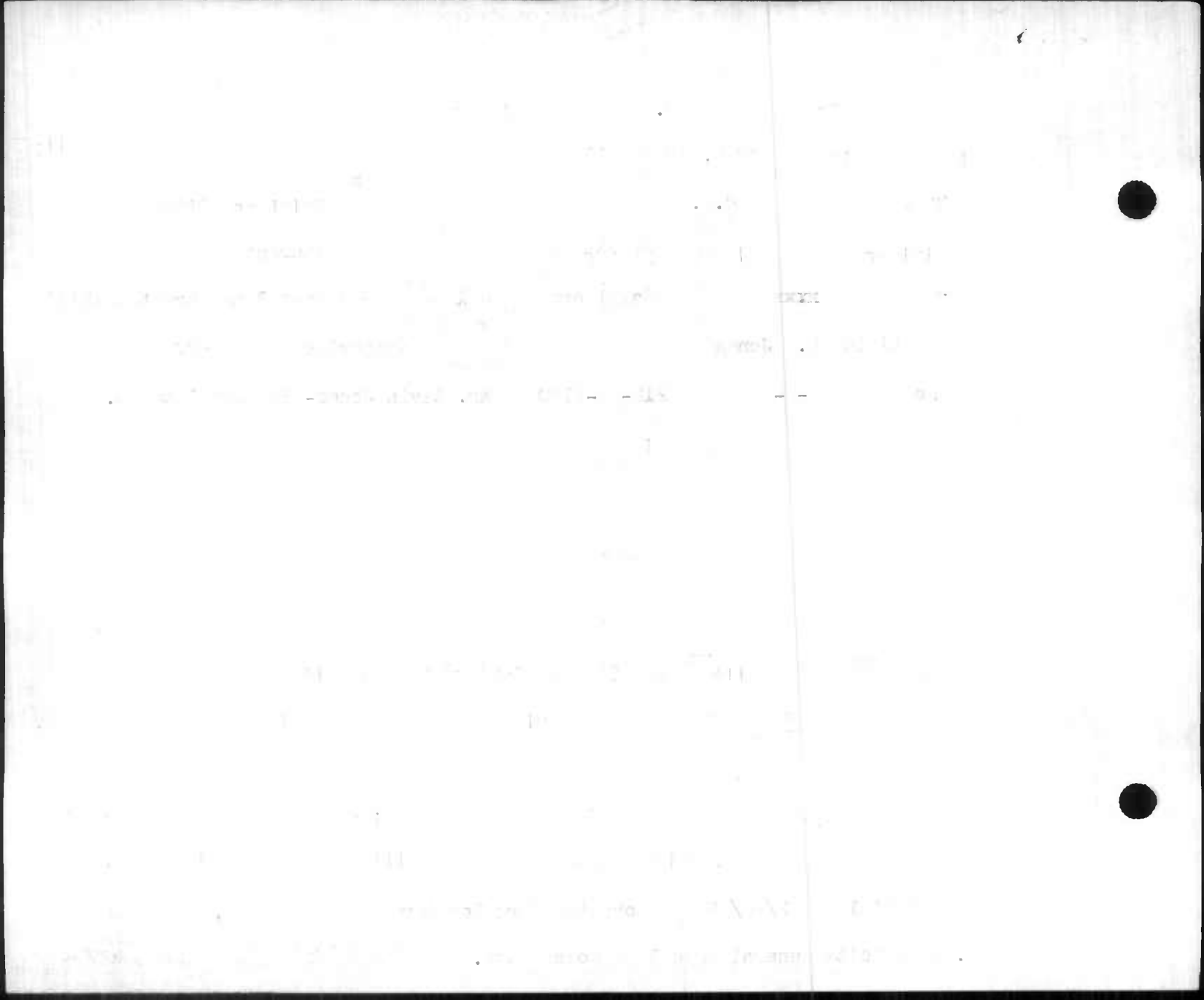
| | | | | | | | | | | | | | | | | | |
|---|--|-------------------------|--|--|--|---|--|---|--|--|--|---|--|---|--|---|--|
| 1. DECEASED NAME
(TYPE OR PRINT) Emma C. Jones | | | | | | | | | | 2a. DATE KNOWN OF DEATH
ESTIMATED <input checked="" type="checkbox"/> MONTH DAY YEAR
2 22 19 82 | | | | 2b. HOUR
11:19
M P M | | | |
| 3. SEX
female | | 4. RACE
negro | | 5. DATE OF BIRTH
MONTH DAY YEAR
4 16 95 | | 6. AGE (IN YEARS)
(LAST BIRTHDAY) YRS.
86 | | IF UNDER 1 YR.
MONTHS DAYS
0 0 | | IF UNDER 24 HRS.
HOURS MIN.
0 0 | | 2c. DATE PRONOUNCED DEAD
MONTH DAY YEAR
2 22 19 82 | | 2d. HOUR
11:19
M P M | | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
MD | | | | 7b. CITIZEN OF WHAT COUNTRY?
USA | | | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | | | 9. BALTIMORE CITY OR COUNTY OF DEATH
Baltimore City
MD. | | | | | |
| 10. CITY OR TOWN OF DEATH
Baltimore | | | | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
420 Manse Court | | | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | | | | 12b. KIND OF BUSINESS OR INDUSTRY | | | |
| 13a. STATE
MD | | | | | | | | | | 13b. COUNTY
Baltimore | | 13c. CITY OR TOWN
Baltimore | | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS
420 Manns Ct. | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
Joseph Cooper | | | | | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
Katherine Brown | | | | | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO, OR UNKNOWN)
No | | | | 16b. SOCIAL SECURITY NO.
N/A | | | | 17. INFORMANT
ADDRESS
Bernard Cooper 420 Manns Ct. | | | | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART 1 DEATH WAS CAUSED BY:
4292 IMMEDIATE CAUSE (a) Arteriosclerotic cardiovascular disease
Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause lost.
(b) _____
(c) _____
DUE TO, OR AS A CONSEQUENCE OF
DUE TO, OR AS A CONSEQUENCE OF
DUE TO, OR AS A CONSEQUENCE OF | | | | | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) _____ | | | | | | | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | | | | | | | | 20. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | |
| 21a. EXTERNAL CAUSE WAS
UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
P.M. 19 | | | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
0 0 0 19 | | | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) | | | | | | | | | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK AT WORK | | | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) | | | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | | | | | | | |
| 22a. I certify that I took charge of the remains described above, held or death resulted from <input checked="" type="checkbox"/> Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> .
Autopsy <input type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion | | | | | | | | | | | | | | | | | |
| ACTUAL SIGNATURE
 | | | | TITLE (SPECIFY)
M.D. Deputy Chief | | | | MEDICAL EXAMINER | | | | DATE SIGNED 2-23-82 | | | | | |
| EXAMINER'S NAME
(TYPE OR PRINT) Thomas D. Smith, M.D. | | | | ADDRESS
111 Penn St. | | | | | | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY) Burial | | | | 23b. DATE
2/26/82 | | 23c. NAME OF CEMETERY OR CREMATORY
Mt. Auburn Cem. | | | | 23d. LOCATION
CITY OR TOWN COUNTY
Baltimore MD | | | | | | | |
| 24. FUNERAL DIRECTOR
NAME
Wm. C. March F/H | | | | | | ADDRESS
1101 E. North Ave. | | | | 25a. DATE REC'D. BY REGISTRAR
FEB 25 1982 | | 25b. REGISTRAR'S SIGNATURE
 | | | | | |



TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

MEDICAL CERTIFICATION

| STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH | | | | | | | | | | REG. NO. 5 2 0 3 8 9 2 | | | | | |
|---|--|--|--|---|--|--|--|---|--|--|--|---|--|-----------------------|--|
| 1- STATE REGISTRAR | | 1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST
Frank D. Jones | | | | | | | | 2a. DATE KNOWN OF DEATH ESTIMATED <input checked="" type="checkbox"/> MONTH DAY YEAR
2 22 19 82 | | 2b. HOUR
M | | | |
| 3. SEX
Male | | 4. RACE
White | | 5. DATE OF BIRTH MONTH DAY YEAR
Nov 2, 1968 | | 6. AGE (IN YEARS LAST BIRTHDAY) 13 YRS | | IF UNDER 1 YR. MONTHS DAYS | | IF UNDER 24 HRS. HOURS MIN. | | 2c. DATE PRONOUNCED DEAD MONTH DAY YEAR
2 22 19 82 | | 2d. HOUR
11:55 P M | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
Maryland | | | | 7b. CITIZEN OF WHAT COUNTRY?
U.S.A | | | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | | | 9. BALTIMORE CITY OR COUNTY OF DEATH
Baltimore City, MD. | | | |
| 10. CITY OR TOWN OF DEATH
Baltimore | | | | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
919 W. 38th Street | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)
Student | | | | 12b. KIND OF BUSINESS OR INDUSTRY | | | |
| USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) | | | | | | | | | | | | | | | |
| 13a. STATE
Maryland | | 13b. COUNTY
Baltimore | | 13c. CITY OR TOWN
Baltimore | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS
919 West 38th Street (21211) | | | | | | | |
| 14. FATHER'S NAME FIRST MIDDLE LAST
Alvin L. Jones | | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST
Katherine Cerrato | | | | | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)
No | | | | 16b. SOCIAL SECURITY NO.
212-90-2190 | | | | 17. INFORMANT ADDRESS
Mr. Alvin Jones-919 West 38th St. | | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I DEATH WAS CAUSED BY:
9530 IMMEDIATE CAUSE (a) <u>Hanging</u>
DUE TO, OR AS A CONSEQUENCE OF
(b) _____
DUE TO, OR AS A CONSEQUENCE OF
(c) _____
Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause lost. | | | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH. | | | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: | | | | | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | | | | | | | | 20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH | | | | 21b. TIME OF INJURY HOUR MIN. MONTH DAY YEAR
11+ P.M. 2 22 19 82 | | | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)
Subject hanged self | | | | | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK | | | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)
home | | | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE
919 W. 38th St. Balto. Md. | | | | | | | |
| 22a. I certify that I took charge of the remains described above, held on death resulted from Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion | | | | | | | | | | | | | | | |
| ACTUAL SIGNATURE  | | | | TITLE (SPECIFY)
M.D. Deputy Chief | | | | MEDICAL EXAMINER | | | | DATE SIGNED. 2/23/82 | | | |
| EXAMINER'S NAME (TYPE OR PRINT)
Thomas D. Smith, M.D. | | | | ADDRESS
III Penn St. Balto., MD. | | | | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)
Burial | | | | 23b. DATE
2/26/82 | | 23c. NAME OF CEMETERY OR CREMATORY
Lorraine Park Cemetery | | | | 23d. LOCATION CITY OR TOWN COUNTY STATE
Baltimore, Maryland | | | | | |
| 24. FUNERAL DIRECTOR NAME
A. Alan Seitz Funeral Home | | | | | | ADDRESS
3818 Roland Ave. | | | | 25a. DATE REC'D. BY REGISTRAR
FEB 26 1982 | | 25b. REGISTRAR'S SIGNATURE
 | | | |



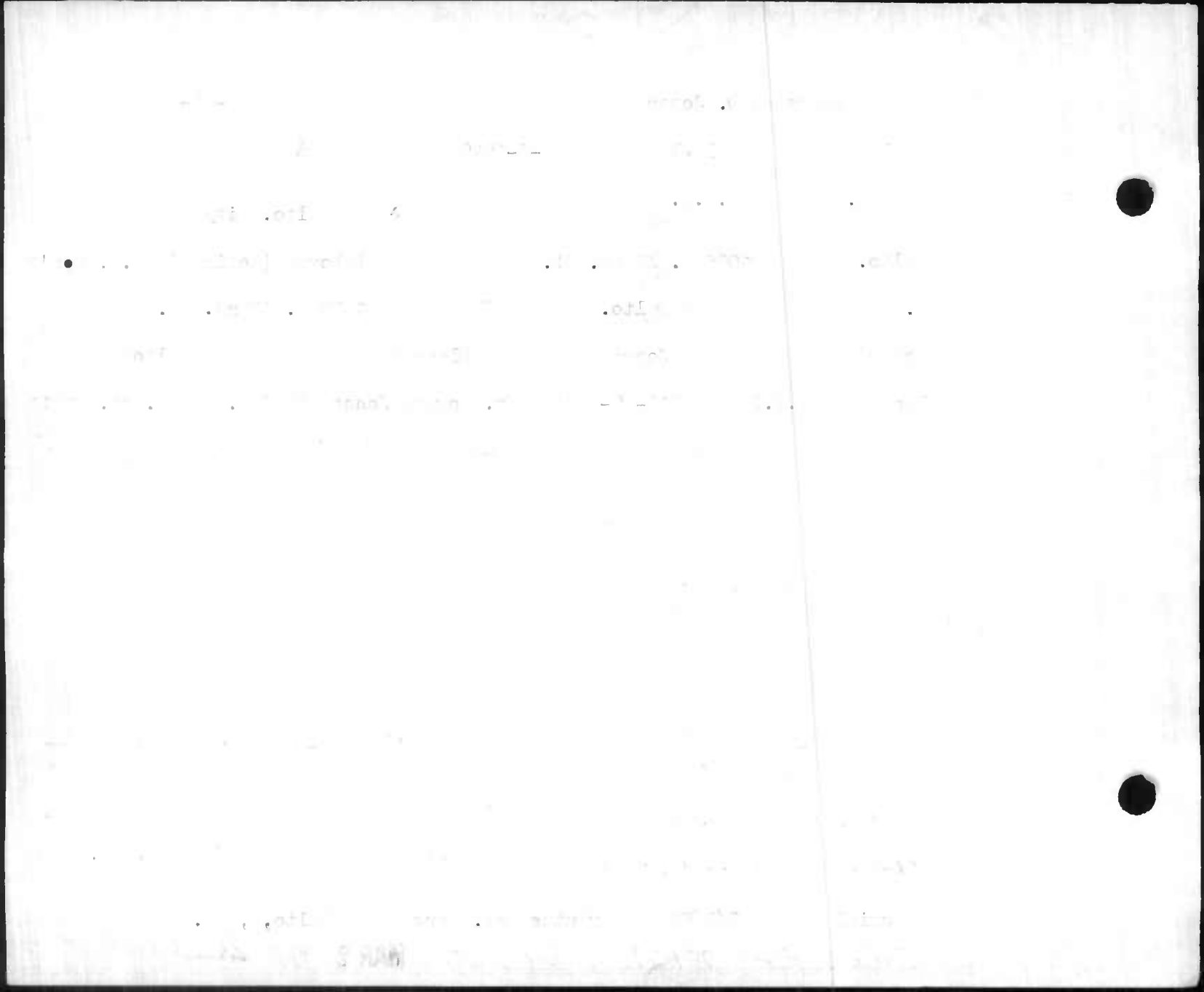
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

MEDICAL CERTIFICATION

| 1 - FOR STATE REGISTRAR | | | | STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH | | | | 8 2 0 3 8 9 3
REG. NO. | | | |
|---|--|---|--|--|--|---|--|--|--|---|--|
| 1. DECEASED NAME (TYPE OR PRINT)
Lawrence D. Jones | | | | | | 2a. DATE OF DEATH MONTH DAY YEAR
2-26-82 | | | | 2b. HOUR
M | |
| 3. SEX
Male | | 4. RACE
Black | | 5. DATE OF BIRTH MONTH DAY YEAR
8-5-1919 | | 6. AGE (IN YEARS (LAST BIRTHDAY))
62 | | 7. IF UNDER 1 YEAR MONTHS DAYS
YRS | | 7. IF UNDER 24 HRS. HOURS MIN
MD | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
Md. | | 7b. CITIZEN OF WHAT COUNTRY?
U.S.A. | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
Balto. City | | | | | |
| 10. CITY OR TOWN OF DEATH
Balto. | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
1005 W. 42 nd. St. | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)
Laborer (Retired) | | 12b. KIND OF BUSINESS OR INDUSTRY
U.S. Gov't | | | |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a STATE
Md. | | | | 13b. COUNTY
Balto. | | 13c. CITY OR TOWN
Balto. | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS
1005 W. 42 nd. St. | |
| 14. FATHER'S NAME FIRST MIDDLE LAST
Howard Jones | | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST
Blanche Walton | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)
Yes | | | | 16b. SOCIAL SECURITY NO.
W.W.II 217-09-6968 | | 17. INFORMANT ADDRESS
Mr. Howard Jones 1005 W. 42 nd. st. 21211 | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))
PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Arteriosclerotic Cardiovascular Heart Disease & failure
4292
DUE TO, OR AS A CONSEQUENCE OF (b) _____
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO, OR AS A CONSEQUENCE OF (c) _____
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
1 month | | | | | | | | | | | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)
Emphysema | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) | | | | | |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 1 May , 19 78 , to 25 Jan , 19 82 , that (I) (we) lost
saw the deceased alive on 25 Jan , 19 82 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated
above. (I) (we) (did) (did not) view the body after death. | | | | | | | | | | | |
| 22b. SIGNATURE
Charles R. Davidson | | | | DEGREE M.D.
ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | | | 22c. DATE SIGNED
1 March 82 | | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
Charles R. Davidson, M.D. | | | | 22e. ADDRESS
2034 West North Ave Baltimore Md. 21217 | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)
Burial | | | | 23b. DATE
3/3/82 | | 23c. NAME OF CEMETERY OR CREMATORY
Arbutus Mem. Park | | 23d. LOCATION CITY OR TOWN COUNTY STATE
Balto. MD. | | | |
| 24. FUNERAL DIRECTOR NAME
Chatman F/H-1701 McCulloch St | | | | ADDRESS
1701 McCulloch St | | 25a. DATE REC'D. BY REGISTRAR
MAR 2 1982 | | 25b. REGISTRAR'S SIGNATURE
James J. [Signature] | | | |



TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, WRITE "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF, MEDICAL EXAMINER ALONG WITH FORM "PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

FOR
1- STATE
REGISTRAR

| | | | | | | | | | | | | | |
|--|---------|--|--|---------------------------|--|---|--|--------------------------------------|--|--------------------------|--|----------|--|
| 1. DECEASED NAME
(TYPE OR PRINT) | | FIRST | | MIDDLE | | LAST | | 2b. DATE KNOWN OF DEATH | | XX MONTH DAY YEAR | | 2d. HOUR | |
| Lebard | | (C.) | | L. | | Jones | | 2 | | 20 | | 19 82 | |
| 3. SEX | 4. RACE | 5. DATE OF BIRTH | | 6. AGE (IN YEARS) | | IF UNDER 1 YR. | | IF UNDER 24 HRS. | | 2c. DATE PRONOUNCED DEAD | | 2d. HOUR | |
| Male | Black | 11 3 50 | | 31 YRS | | MONTHS DAYS | | HOURS MIN | | 2 20 19 82 | | 10:10 | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) | | 7b. CITIZEN OF WHAT COUNTRY? | | 8. MARRIED | | NEVER MARRIED | | 9. BALTIMORE CITY OR COUNTY OF DEATH | | | | | |
| MD | | USA | | WIDOWED | | DIVORCED | | Baltimore City, | | | | MD | |
| 10. CITY OR TOWN OF DEATH | | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION | | 12a. USUAL OCCUPATION | | 12b. KIND OF BUSINESS OR INDUSTRY | | | | | | | |
| Baltimore | | Provident Hospital | | FOR MOST OF WORKING LIFE) | | | | | | | | | |
| 13a. STATE | | 13b. COUNTY | | 13c. CITY OR TOWN | | 13d. INSIDE CITY LIMITS? | | 13e. STREET ADDRESS | | | | | |
| MD | | | | Baltimore | | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 1706 N. Calhoun St. | | | | | |
| 14. FATHER'S NAME | | MIDDLE | | LAST | | 15. MOTHER'S MAIDEN NAME | | MIDDLE | | LAST | | | |
| Norman | | L. | | Jones | | Helen | | Whitehead | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? | | 16b. SOCIAL SECURITY NO | | 17. INFORMANT | | ADDRESS | | | | | | | |
| No | | 216-52-0944 | | Helen Jones | | 1706 N. Calhoun St. | | | | | | | |

18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I DEATH WAS CAUSED BY:

9650 IMMEDIATE CAUSE (a) Gunshot wound to Chest (handgun)
DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.
(b)
DUE TO, OR AS A CONSEQUENCE OF
(c)

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)

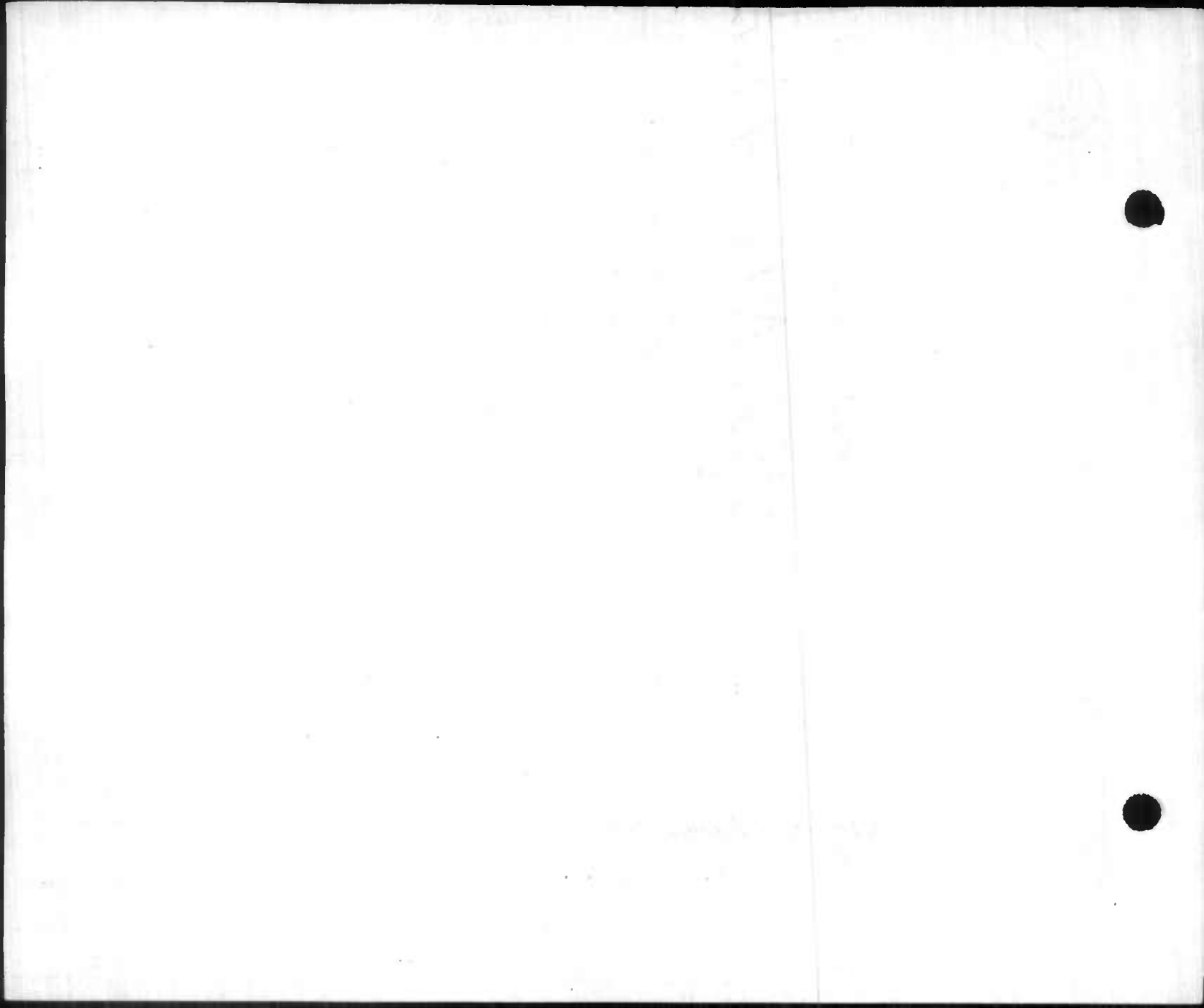
| | | | | | |
|--|--|---|--|---|--|
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | | 20. AUTOPSY? | |
| | | | | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH | | 21b. TIME OF INJURY
HOUR XXXX MONTH DAY YEAR
9:30 P.M. 2 20 19 82 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)
subject was shot | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK | | 21e. PLACE OF INJURY (AT HOME STREET, FACTORY, FARM, ETC.)
street | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE
1700 blk. Calhoun St., Baltimore, Maryland | |

22a. I certify that I took charge of the remains described above, held an Autopsy ☒ Inspection ☐ Inquiry ☐ and in my opinion death resulted from: Natural causes ☐ Accident ☐ Suicide ☐ Homicide ☒ Undetermined manner ☐.

ACTUAL SIGNATURE *Virginia L. Dolan* M.D. Assistant MEDICAL EXAMINER TITLE (SPECIFY) DATE SIGNED 2-21-82

EXAMINER'S NAME (TYPE OR PRINT) Virginia L. Dolan, M.D. ADDRESS 111 Penn Street

| | | | | | | | | | | | |
|---|--|-----------|--|------------------------------------|--|----------------------------|--|----------------------------|--|-------|--|
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) | | 23b. DATE | | 23c. NAME OF CEMETERY OR CREMATORY | | 23d. LOCATION CITY OR TOWN | | COUNTY | | STATE | |
| Burial | | 2/26/82 | | Arbutus Memorial | | Baltimore | | Co. | | MD | |
| 24. FUNERAL DIRECTOR NAME | | | | 25a. DATE REC'D. BY REGISTRAR | | | | 25b. REGISTRAR'S SIGNATURE | | | |
| Wm. C. March F/H | | | | 1101 E. North Ave. | | | | FEB 22 1982 | | | |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

Items 1,5,6 g565 3/4/82 g3

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 2 0 3 8 9 5

1- FOR
STATE
REGISTRAR

REG. NO.

| | | | | | |
|--|--|---|---|--|--|
| 1. DECEASED NAME
(TYPE OR PRINT)
FIRST MARY MIDDLE Drucilla LAST Jones | | | 2a. DATE OF DEATH
MONTH DAY YEAR
2 12 82 | | 2b. HOUR
12 ³⁰ PM |
| 3. SEX
Female | 4. RACE
Black | 5. DATE OF BIRTH
MONTH DAY YEAR
12 05 1905 | 6. AGE (IN YEARS LAST BIRTHDAY)
77-76 YRS. | | IF UNDER 1 YEAR
MONTHS DAYS
IF UNDER 24 HRS.
HOURS MIN. |
| 7a. BIRTHPLACE
(STATE OR FOREIGN COUNTRY)
SNOWHILL, MD | 7b. CITIZEN OF WHAT COUNTRY?
USA | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 9. BALTIMORE CITY OR COUNTY OF DEATH
Baltimore City MD. | | |
| 10. CITY OR TOWN OF DEATH
Baltimore City | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
Sinai Hospital of Baltimore | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE) | | 12b. KIND OF BUSINESS OR INDUSTRY |
| 13a. STATE
MD | 13b. COUNTY | 13c. CITY OR TOWN
Baltimore City | 13d. INSIDE CITY LIMITS?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | 13e. STREET ADDRESS
3913 Mondawmin Ave 21216 | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
WILLIAM YOUNG | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
ELLEN DESMOND | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
NO | | 16b. SOCIAL SECURITY NO.
220-14-5744 | 17. INFORMANT
ADDRESS
CORTHA CUTHBERT 700 LENOX AVE APT. 22-A | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART 1. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Septic Shock
5770
DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b) Hemorrhagic Pancreatitis
DUE TO, OR AS A CONSEQUENCE OF
(c) | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) | | | | | |
| 19a. DATE OF OPERATION
2/11/82 | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED
Acute Abdomen | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | |
| 21d. INJURY OCCURRED
WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | |
| 22a. I certify that (this hospital) attended the deceased from 2/9 19 82, to 2/12 19 82, that (1) saw the deceased alive on 2/12 19 82, and that in my opinion death occurred on the date and hour and from the causes stated above, (1) (we) (did) (did not) view the body after death. | | | | | |
| 22b. SIGNATURE
Jeffrey H. Chircus MD | | | | 22c. DATE SIGNED
2/12/82 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
JEFFREY H. CHIRCUS M.D. | | | | 22e. ADDRESS
Sinai Hospital of Baltimore | |
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)
BURIAL | | 23b. DATE
2/18/82 | | 23c. NAME OF CEMETERY OR CREMATORY
KING MEMORIAL PARK | |
| 23d. LOCATION
CITY OR TOWN COUNTY STATE
BALTIMORE Co. MD | | 24. FUNERAL DIRECTOR
NAME ADDRESS
WM. C. MARCH F/H 1101 E. NORTH AVE, | | | |
| 25a. DATE REC'D. BY REGISTRAR
FEB 16 1982 | | | | 25b. REGISTRAR'S SIGNATURE
Thane Jan... | |

25-77

पत्र सं २१



TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES.

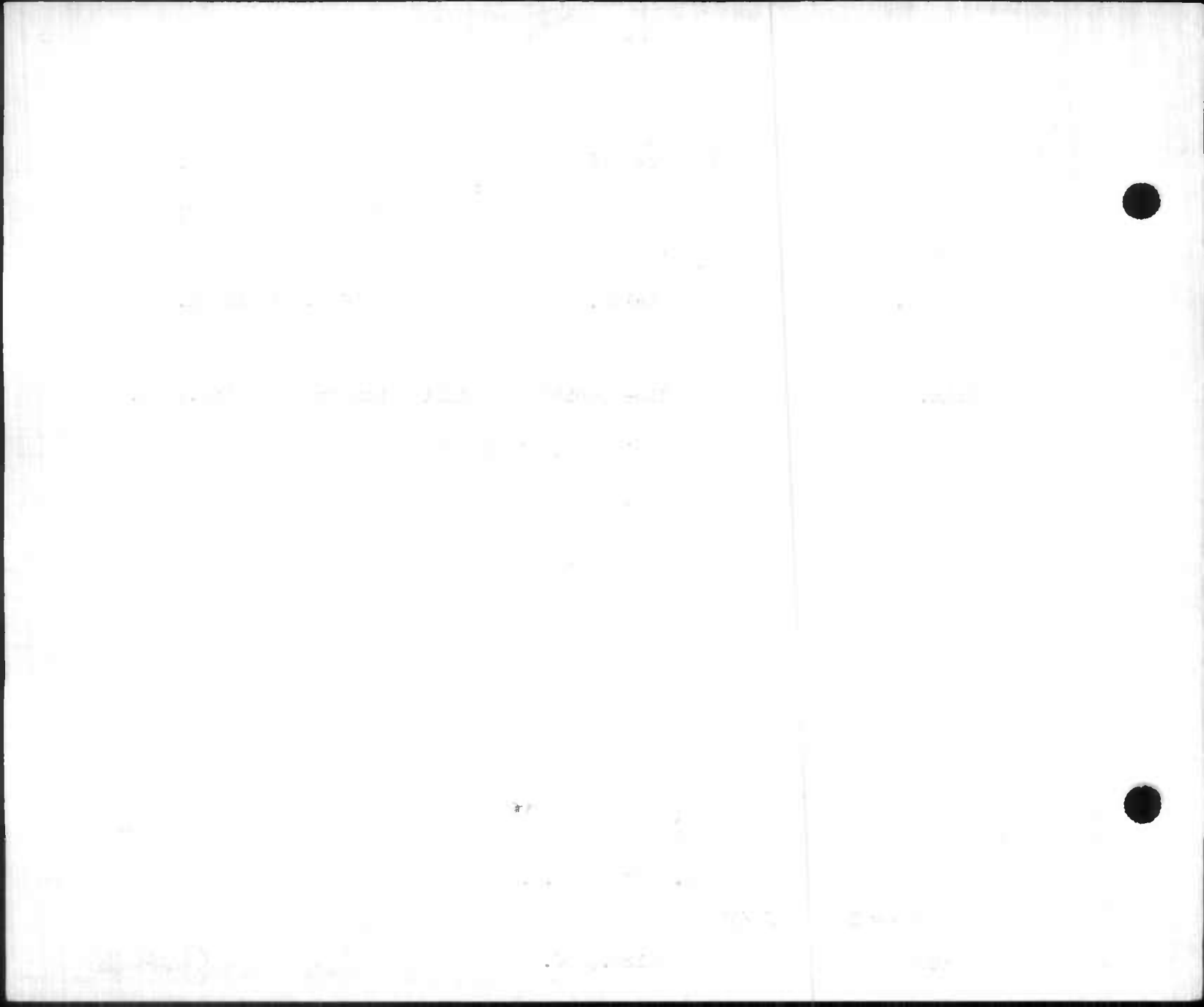
TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESIDENT STREET, BALTIMORE, MARYLAND, 21201. PRIOR TO BURIAL, CREMATION, OR REMOVAL.

DHMH-17
(VR A15 ME (5))
15M2/80

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

| FOR STATE REGISTRAR | | | | | | DEPARTMENT OF HEALTH AND MENTAL HYGIENE | | | | | | REG. NO. | | | | | | | | | | | | | | | | | |
|--|--|--|--|--|--|--|--|--|--|--|--|---|--|--|--|--|--|--|--|--|--|--|--|---------------------|--|--|--|--|--|
| 1. DECEASED NAME
(TYPE OR PRINT) | | | | | | FIRST MIDDLE LAST | | | | | | 2a. DATE KNOWN OF DEATH ESTIMATED | | | | | | MONTH DAY YEAR | | | | | | | | | | | |
| RICHARD JONES | | | | | | | | | | | | 2-4-82 19 | | | | | | | | | | | | | | | | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) | | | | | | 7b. CITIZEN OF WHAT COUNTRY? | | | | | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | | | | | 9. BALTIMORE CITY OR COUNTY OF DEATH | | | | | | | | | | | |
| Baltimore | | | | | | ✓ | | | | | | | | | | | | Baltimore City MD | | | | | | | | | | | |
| 10. CITY OR TOWN OF DEATH | | | | | | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) | | | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | | | | | | 12b. KIND OF BUSINESS OR INDUSTRY | | | | | | | | | | | |
| Baltimore | | | | | | 436 E. Biddle Street | | | | | | | | | | | | | | | | | | | | | | | |
| 13a. STATE | | | | | | 13b. COUNTY | | | | | | 13c. CITY OR TOWN | | | | | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | | | | 13e. STREET ADDRESS | | | | | |
| Md. | | | | | | | | | | | | Balto. | | | | | | YES | | | | | | 436 E. Biddle St. | | | | | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST | | | | | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST | | | | | | | | | | | | | | | | | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO, OR UNKNOWN) (IF YES, GIVE WAR OR DATES) | | | | | | 16b. SOCIAL SECURITY NO. | | | | | | 17 INFORMANT | | | | | | ADDRESS | | | | | | | | | | | |
| Unkn. | | | | | | 250-03-0590 | | | | | | William Parham | | | | | | Balto., Md. | | | | | | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I DEATH WAS CAUSED BY:
<u>4292</u> IMMEDIATE CAUSE (a) <u>Arteriosclerotic cardiovascular disease</u>
DUE TO, OR AS A CONSEQUENCE OF
(b) _____
DUE TO, OR AS A CONSEQUENCE OF
(c) _____
Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. | | | | | | | | | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | | | | | | | | | | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I a. | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | | | | | | 20 AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | | | | | | | | | | | | | |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH | | | | | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | | | | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2) | | | | | | | | | | | | | | | | | |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | | | | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) | | | | | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | | | | | | | | | | | | | | | |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> . | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| ACTUAL SIGNATURE <u>Margie A. Korall</u> | | | | | | TITLE (SPECIFY) M.D. Assistant MEDICAL EXAMINER | | | | | | DATE SIGNED 2-5-82 | | | | | | | | | | | | | | | | | |
| EXAMINER'S NAME (TYPE OR PRINT) | | | | | | ADDRESS | | | | | | | | | | | | | | | | | | | | | | | |
| Margarita A. Korall, M.D. | | | | | | 111 Penn Street | | | | | | | | | | | | | | | | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) | | | | | | 23b. DATE | | | | | | 23c. NAME OF CEMETERY OR CREMATORY | | | | | | 23d. LOCATION
CITY OR TOWN COUNTY STATE | | | | | | | | | | | |
| Removal | | | | | | 2/4/82 | | | | | | | | | | | | | | | | | | | | | | | |
| 24 FUNERAL DIRECTOR
NAME ADDRESS | | | | | | 25a. DATE REC'D. BY REGISTRAR | | | | | | 25b. REGISTRAR'S SIGNATURE | | | | | | | | | | | | | | | | | |
| Anatomy Board Balto., Md. | | | | | | FEB 6 1982 | | | | | | <u>[Signature]</u> | | | | | | | | | | | | | | | | | |



BP

DHMH - 16 50M 1/B1
(VRA 15, 4)

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 12 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

FOR
1 - STATE
REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

8 2 0 3 8 9 7

| | | | | | |
|---|--|--|--|---|---|
| 1. DECEASED NAME
(TYPE OR PRINT) RUSSELL LEE JONES SR. | | | 2a. DATE OF DEATH
MONTH DAY YEAR
February 17 1982 | | 2b. HOUR
MIN.
12 PM |
| 3. SEX
MALE | 4. RACE
White | 5. DATE OF BIRTH
MONTH DAY YEAR
6 24 1926 | 6. AGE (IN YEARS LAST BIRTHDAY)
55 YRS | 7. IF UNDER 1 YEAR
MONTHS DAYS HOURS MIN.
55 | |
| 8. BIRTHPLACE
(STATE OR FOREIGN COUNTRY)
MD | 9. CITIZEN OF WHAT COUNTRY?
USA | 10. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 11. BALTIMORE CITY OR COUNTY OF DEATH
Baltimore City MD. | | |
| 12. CITY OR TOWN OF DEATH
Baltimore | 13. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
South Baltimore G.H. | | 14. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
C.H. Mullenberg Co. | | 15. KIND OF BUSINESS OR INDUSTRY |
| 16. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)
13a. STATE MD. 13b. COUNTY A.A. 13c. CITY OR TOWN Pasadena | | | 17. INSIDE CITY LIMITS?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | |
| 18. FATHER'S NAME
FIRST MIDDLE LAST
William Lee JONES | | | 19. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
ANNA Mary HAGGIS | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
Yes | | 16b. SOCIAL SECURITY NO.
W.W. II 216 20 2022 | | 17. INFORMANT
ADDRESS
Pasadena, Md. 21122
Grace E. Jones 691 Duvall Hgwy | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART 1. DEATH WAS CAUSED BY:
1629 IMMEDIATE CAUSE (a) Respiratory insufficiency
DUE TO, OR AS A CONSEQUENCE OF (b) Metastatic lung disease
DUE TO, OR AS A CONSEQUENCE OF (c) Lung carcinoma
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: NO | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | |
| 22a. I certify that (I) (this hospital) attended the deceased from 2/11 19 82 to 2/17 19 82 , that <input checked="" type="checkbox"/> (we) lost saw the deceased alive on 2/17 19 82 , and that in <input checked="" type="checkbox"/> (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | |
| 22b. SIGNATURE
Armando Sardi | | DEGREE
M.D. ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> | | 22c. DATE SIGNED
2/12/82 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
ARMANDO SARDI | | 22e. ADDRESS
SB5H | | | |
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)
Burial | | 23b. DATE
2/20/82 | | 23c. NAME OF CEMETERY OR CREMATORY
Glen Haven Mem Pk | |
| 24. FUNERAL DIRECTOR
NAME
George J. Gonce | | ADDRESS
Balto Md. 21225 | | 25a. DATE REC'D. BY REGISTRAR
FEB 19 1982 | |
| | | | | 25b. REGISTRAR
Charles J. Nathan | |

MEDICAL CERTIFICATION

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 2 0 3 8 9 8

1- FOR
STATE
REGISTRAR

REG. NO.

| | | | | | |
|---|--|---|---|--|---|
| 1. DECEASED NAME
(TYPE OR PRINT)
FIRST MIDDLE LAST
<i>William Amos Jones</i> | | | 2a. DATE OF DEATH
MONTH DAY YEAR
<i>2-27-82</i> | | 2b. HOUR
<i>950 M</i> |
| 3. SEX
<i>MALE</i> | 4. RACE
<i>Black</i> | 5. DATE OF BIRTH
MONTH DAY YEAR
<i>8-9-1899</i> | | 6. AGE (IN YEARS LAST BIRTHDAY)
<i>82</i> YRS | IF UNDER 1 YEAR
MONTHS DAYS HOURS MIN. |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
<i>Md.</i> | 7b. CITIZEN OF WHAT COUNTRY?
<i>USA</i> | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
<i>City, BALTO MD.</i> | |
| 10. CITY OR TOWN OF DEATH
<i>Balto.</i> | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
<i>Key Circle Hospice</i> | | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
<i>Custodian</i> | 12b. KIND OF BUSINESS OR INDUSTRY |
| 13a. STATE
<i>Md.</i> | 13b. COUNTY | 13c. CITY OR TOWN
<i>Balto</i> | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | 13e. STREET ADDRESS
<i>2205 W. Saratoga ST.</i> | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
<i>JEFFERSON</i> | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
<i>LOUISE</i> | | 16. ADDRESS | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
<i>NO</i> | | 16b. SOCIAL SECURITY NO. | | 17. INFORMANT
<i>Ann Moore</i> | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <i>Coma</i>
<i>4360</i>
DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last:
(b) <i>Cerebral Vase. Accident</i>
DUE TO, OR AS A CONSEQUENCE OF
(c) <i>C.A.S. senility</i>
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:
<i>Diabetes mellitus - C.H.F.</i> | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK AT WORK | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | |
| 22a. I certify that (a) (this hospital) attended the deceased from <i>4/19</i> 19 <i>73</i> to <i>2/27</i> 19 <i>82</i> , that (we) lost saw the deceased alive on <i>2/27</i> 19 <i>82</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did not) view the body after death. | | | | | |
| 22b. SIGNATURE
<i>Kenneth Krulovitz MD</i> | | | | 22c. DATE SIGNED
<i>3/1/82</i> | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
<i>Kenneth Krulovitz MD</i> | | | | 22e. ADDRESS
<i>115 W. Monument ST. (21201)</i> | |
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)
<i>BURIAL</i> | | 23b. DATE
<i>3/5/82</i> | | 23c. NAME OF CEMETERY OR CREMATORY
<i>Mt. Auburn Cem.</i> | |
| 23d. LOCATION
CITY OR TOWN COUNTY STATE
<i>BALTIMORE MD.</i> | | 24. FUNERAL DIRECTOR
NAME ADDRESS
<i>LE ROY HARRIS F. #5 4520 PEN LUCY RD.</i> | | | |
| 25a. DATE REC'D. BY REGISTRAR | | 25b. REGISTRAR'S SIGNATURE
<i>Frances Jean Nathan</i> | | | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death, and it should be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

P

REV



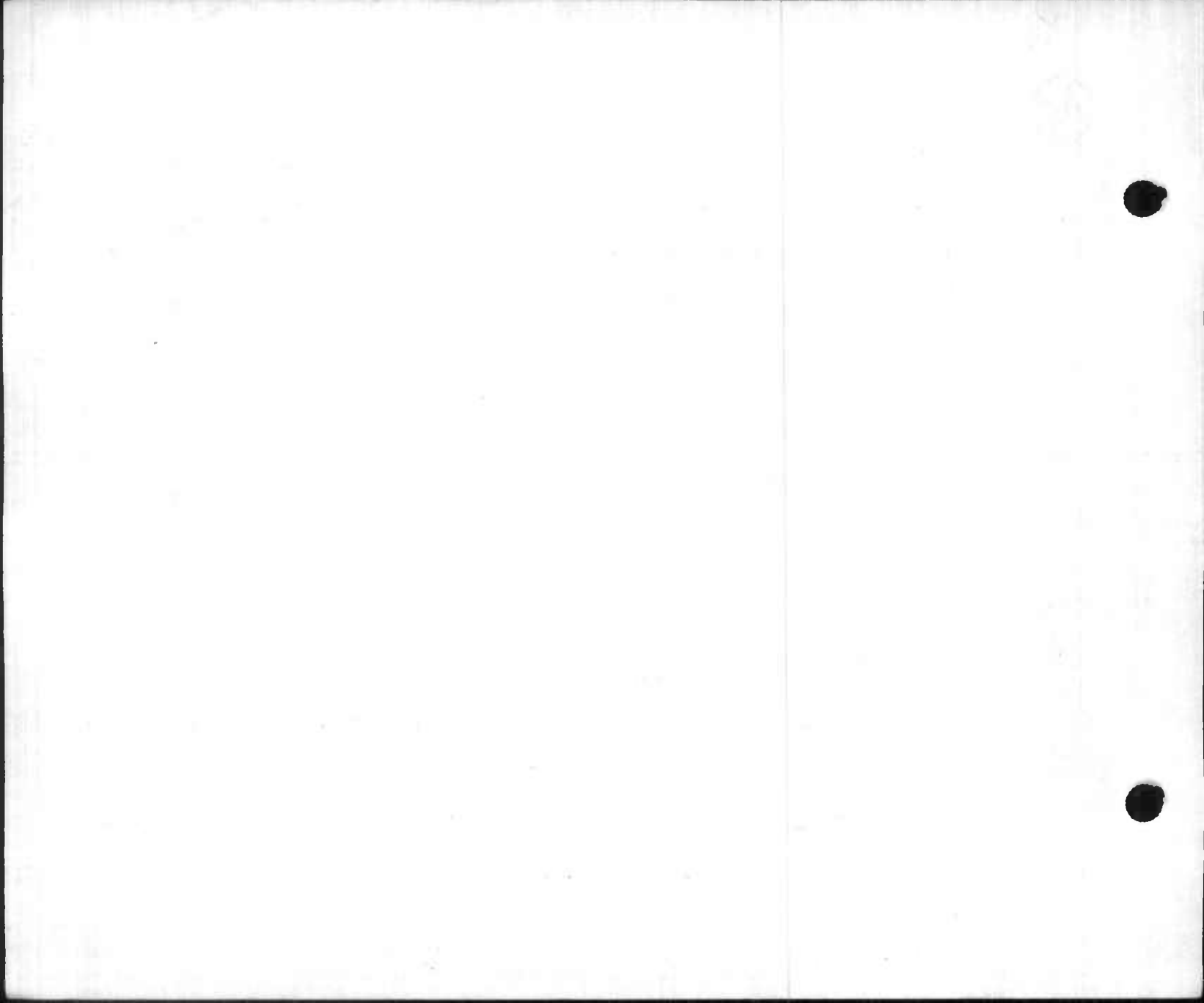
TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. GIVE PAGE 4 TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PA 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

FOR
1- REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | | | | | | | | | | | |
|--|--|--|--|--|--|--|--|---|--|-----------------------------------|--|----------------------------|--|--|--|---|--|
| 1. DECEASED NAME
(TYPE OR PRINT) | | FIRST | | MIDDLE | | LAST | | 2b. DATE KNOWN OF DEATH | | XX MONTH DAY YEAR | | 2c. DATE PRONOUNCED DEAD | | XX MONTH DAY YEAR | | 2d. HOUR | |
| VICTORIA | | | | | | KALBARCZYK | | 2b. DATE KNOWN OF DEATH | | XX MONTH DAY YEAR | | 2c. DATE PRONOUNCED DEAD | | XX MONTH DAY YEAR | | 2d. HOUR | |
| 3. SEX | | 4. RACE | | 5. DATE OF BIRTH | | 6. AGE (IN YEARS) | | IF UNDER 1 YR. | | IF UNDER 24 HRS. | | 7c. DATE PRONOUNCED DEAD | | 8. MARRIED | | 9. BALTIMORE CITY OR COUNTY OF DEATH | |
| female | | white | | Jan. 24, 1920 | | 62 YRS | | MONTHS | | DAYS | | 2c. DATE PRONOUNCED DEAD | | WIDOWED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | Baltimore City | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) | | 7b. CITIZEN OF WHAT COUNTRY? | | 10. CITY OR TOWN OF DEATH | | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | | 12b. KIND OF BUSINESS OR INDUSTRY | | 13a. STREET ADDRESS | | 13b. COUNTY | | 13c. CITY OR TOWN | |
| Pennsylvania | | U.S.A. | | Baltimore | | 5413 Pembroke Avenue | | Cashier | | A & P | | 5413 Pembroke Ave. | | Baltimore | | Baltimore | |
| 14. FATHER'S NAME | | 15. MOTHER'S MAIDEN NAME | | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? | | 16b. SOCIAL SECURITY NO. | | 17. INFORMANT | | 18. CAUSE OF DEATH | | 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | | 20. AUTOPSY? | |
| Alex | | Anna | | No | | 165-16-3576 | | Sharon Kalbarczyk | | 9654 | | | | | | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| FIRST | | LAST | | (YES, NO, OR UNKNOWN) | | (IF YES, GIVE WAR OR DATES) | | 1951 | | Gunshot wounds of head | | | | | | | |
| PART 1 DEATH WAS CAUSED BY: | | IMMEDIATE CAUSE (a) | | DUE TO, OR AS A CONSEQUENCE OF | | (b) | | DUE TO, OR AS A CONSEQUENCE OF | | (c) | | | | | | | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) | | | | | | | | | | | | | | | | | |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH | | 21b. TIME OF INJURY | | 21c. HOW INJURY OCCURRED | | 21d. INJURY OCCURRED | | 21e. PLACE OF INJURY | | 21f. LOCATION | | 21g. LOCATION | | 21h. LOCATION | | 21i. LOCATION | |
| WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> | | 9AM P.M. 2-5-82 | | subject shot | | at home | | 5413 Pembroke Ave. | | Baltimore | | Baltimore | | Baltimore | | Baltimore | |
| 22a. I certify that I took charge of the remains described above, held an | | Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion | | death resulted from: | | Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input checked="" type="checkbox"/> Undetermined manner <input type="checkbox"/> | | TITLE (SPECIFY) | | M.D. Assistant | | DATE SIGNED | | 2-5-82 | | | |
| ACTUAL SIGNATURE | | Margarita A. Korell, M.D. | | ADDRESS | | 111 Penn Street | | | | | | | | | | | |
| EXAMINER'S NAME (TYPE OR PRINT) | | 23a. BURIAL, CREMATION, REMOVAL | | 23b. DATE | | 23c. NAME OF CEMETERY OR CREMATORY | | 23d. LOCATION | | 23e. DATE REC'D. BY REGISTRAR | | 23f. REGISTRAR'S SIGNATURE | | 23g. REGISTRAR'S SIGNATURE | | 23h. REGISTRAR'S SIGNATURE | |
| Burial | | Feb. 9, 1982 | | Gardens of Faith | | Baltimore | | Maryland | | FEB 8 1982 | | Name | | Name | | Name | |
| 24. FUNERAL DIRECTOR | | 25. DATE REC'D. BY REGISTRAR | | 25. REGISTRAR'S SIGNATURE | | 25. REGISTRAR'S SIGNATURE | | 25. REGISTRAR'S SIGNATURE | | 25. REGISTRAR'S SIGNATURE | | 25. REGISTRAR'S SIGNATURE | | 25. REGISTRAR'S SIGNATURE | | 25. REGISTRAR'S SIGNATURE | |
| Leonard J. Ruck, Inc. | | FEB 8 1982 | | Name | | Name | | Name | | Name | | Name | | Name | | Name | |

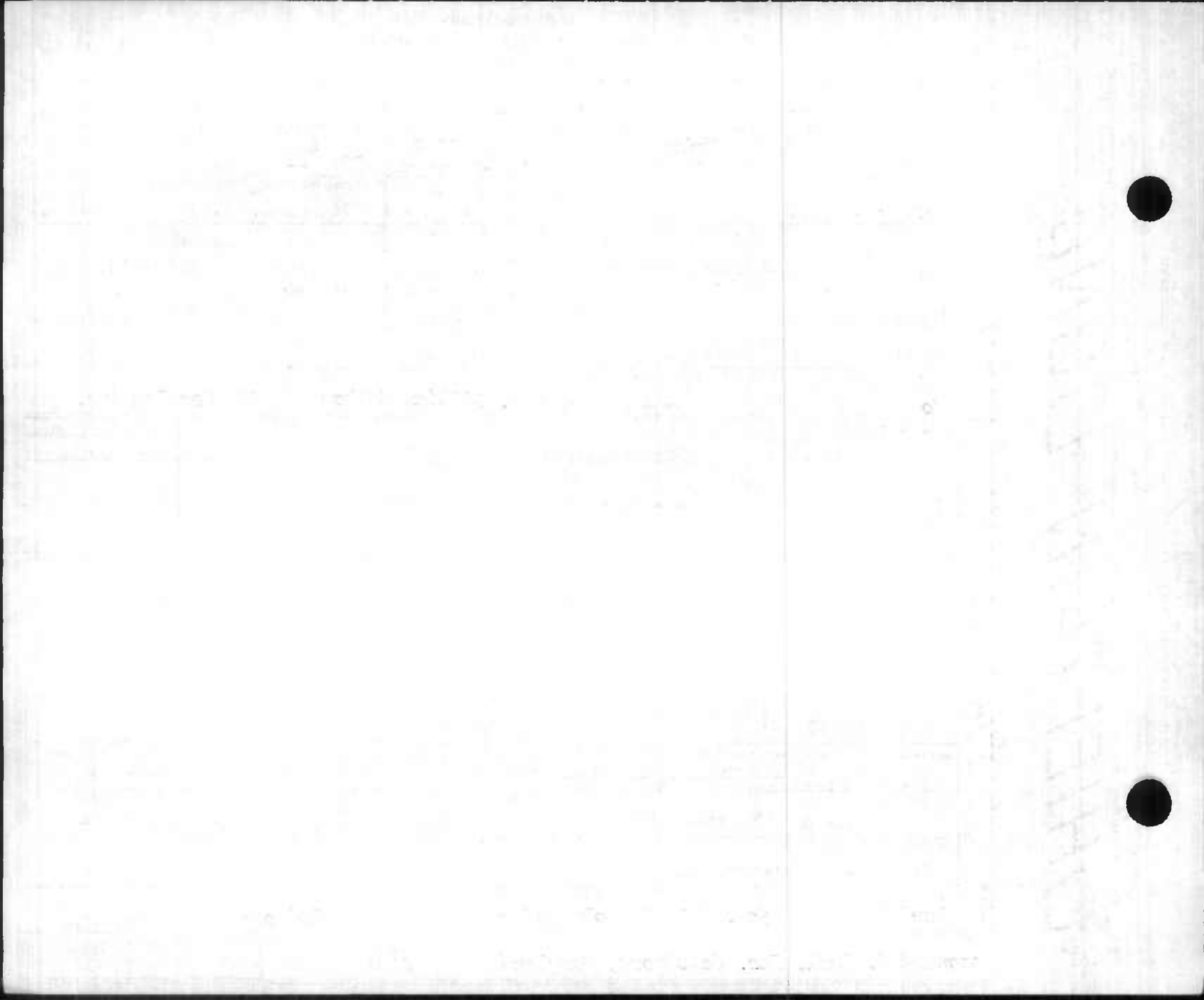


TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the medical director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 24 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

| STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH | | | | 8 2 0 3 9 0 0 | | | |
|--|--|---|--|---|--|--|---|
| 1. FOR STATE REGISTRAR | | | | REG. NO. | | | |
| 1. DECEASED NAME
(TYPE OR PRINT) FIRST MIDDLE LAST
EDWARD KALKOWSKI | | | | 2a. DATE OF DEATH MONTH DAY YEAR
Feb. 5 1982 | | | |
| 3. SEX
Male | | | | 2b. HOUR
12⁰⁵ AM | | | |
| 4. RACE
White Caucasian | | 5. DATE OF BIRTH MONTH DAY YEAR
Sept 2 1900 | | 6. AGE (IN YEARS LAST BIRTHDAY)
72 7/19 YRS. | | IF UNDER 1 YEAR
MONTHS DAYS HOURS MIN. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
USA Maryland | | 7b. CITIZEN OF WHAT COUNTRY?
USA | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
Baltimore City MD. | |
| 10. CITY OR TOWN OF DEATH
Baltimore | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
Union Memorial Hospital | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
Clerk | | 12b. KIND OF BUSINESS OR INDUSTRY
Supply | |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)
13a. STATE
Md | | | | 13b. COUNTY
Baltimore | | | |
| 13c. CITY OR TOWN
Baltimore | | | | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | |
| 13e. STREET ADDRESS
4203 Woodlea Ave. | | | | | | | |
| 14. FATHER'S NAME FIRST MIDDLE LAST
Peter Kalkowski | | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST
Helen Urbanski | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
No | | 16b. SOCIAL SECURITY NO.
212 03 1303 | | 17. INFORMANT ADDRESS
M. Lillian Kalkowski 4203 Woodlea Ave. | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART 1. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Cardiac arrest
DUE TO, OR AS A CONSEQUENCE OF
(b) Massive acute anterior MI
DUE TO, OR AS A CONSEQUENCE OF
(c) _____
CONDITIONS, IF ANY, WHICH GAVE RISE TO IMMEDIATE CAUSE (a), STATING THE UNDERLYING CAUSE LAST.
4100 | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
immediate
24 hrs |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) | | | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> AT WORK
NOT WHILE <input type="checkbox"/> AT WORK | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 1-30 , 19 82 , to 2-5 , 19 82 , that (I) (we) lost
saw the deceased alive on 2-4 , 19 82 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated
above. (I) (we) (do) (did not) view the body after death. | | | | | | | |
| 22b. SIGNATURE
Candace Chandler MD | | | | DEGREE
ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> | | 22c. DATE SIGNED
2-5-82 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
CANDACE CHANDLER | | | | 22e. ADDRESS
UNION MEMORIAL HOSPITAL Balto. Md. | | | |
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)
Burial | | 23b. DATE
Feb. 8, 1982 | | 23c. NAME OF CEMETERY OR CREMATORY
Holy Redeemer | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
Baltimore Maryland | |
| 24. FUNERAL DIRECTOR
NAME
Leonard J. Ruck, Inc. Baltimore, Maryland | | | | 25a. DATE REC'D. BY REGISTRAR
FEB 8 1982 | | 25b. REGISTRAR'S SIGNATURE
<i>James J. [Signature]</i> | |



TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the death certificate with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be consulted.

| STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH | | | | | | | | | | 8 2 0 3 9 0 1 | |
|---|--|---|--|---|--|---|--|---|--|---|--|
| 1. FOR
STATE
REGISTRAR | | REG. NO. | | | | | | | | | |
| 1. DECEASED NAME
(TYPE OR PRINT) | | FIRST
<i>NELLIE</i> | | MIDDLE
<i>Irene</i> | | LAST
<i>KAMINKOW</i> | | 2a. DATE OF DEATH
MONTH DAY YEAR
<i>2 9 82</i> | | 2b. HOUR
<i>5:45 PM</i> | |
| 3. SEX
<i>F</i> | | 4. RACE
<i>C</i> | | 5. DATE OF BIRTH
MONTH DAY YEAR
<i>May 16, 1921</i> | | 6. AGE (IN YEARS (LAST BIRTHDAY))
YRS
<i>60</i> | | 7. IF UNDER 1 YEAR
MONTHS DAYS
<i></i> | | 7b. IF UNDER 1 YEAR
HOURS MIN.
<i></i> | |
| 7a. BIRTHPLACE
(STATE OR FOREIGN COUNTRY)
<i>md</i> | | 7b. CITIZEN OF WHAT COUNTRY?
<i>USA</i> | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
<i>Baltimore City</i> MD. | | | | | |
| 10. CITY OR TOWN OF DEATH
<i>Baltimore City</i> | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
<i>SINAI</i> | | | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
<i>Homemaker</i> | | 12b. KIND OF BUSINESS OR INDUSTRY
<i></i> | | | |
| 13a. STATE
<i>md</i> | | 13b. COUNTY
<i>Baltimore</i> | | 13c. CITY OR TOWN
<i>COCKEYSVILLE</i> | | 13d. INSIDE CITY LIMITS?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 13e. STREET ADDRESS
<i>4-F GINGERVIEW CT</i> | | | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
<i>Charles Milton Kemp</i> | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
<i>Mary Mildred Jones</i> | | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
<i>No</i> | | 16b. SOCIAL SECURITY NO.
(IF YES, GIVE WAR OR DATES)
<i>212-14-70504</i> | | 17. INFORMANT
ADDRESS
<i>Mr. Maurice Kaminkow 21030
F Ginger View Court Cockeysville, MD.</i> | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:
<i>1629 resp failure</i>
IMMEDIATE CAUSE (a) <i>resp failure</i>
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last:
(b) <i>lung can = total body mets</i>
DUE TO, OR AS A CONSEQUENCE OF
(c) <i></i> | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
<i></i> | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <i></i> | | | | | | | | | | | |
| 19a. DATE OF OPERATION
<i></i> | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED
<i></i> | | | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. <i>N/A 19</i> | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)
<i>N/A</i> | | | | | | | |
| 21d. INJURY OCCURRED
WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>
<i>NA</i> | | 21e. PLACE OF INJURY
(AT HOME STREET FACTORY OFFICE FARM, ETC.)
<i>NA</i> | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE
<i>N/A</i> | | | | | | | |
| 22a. I certify that (i) this hospital attended the deceased from <i>2/1</i> 19 <i>82</i> , to <i>2/9</i> 19 <i>82</i> , and that (ii) (we) (did) view the deceased alive on above, (ii) (we) (did) view the body after death. | | | | | | | | | | | |
| 22b. SIGNATURE
<i>John E Gordon MD</i> | | DEGREE
<i>MD</i> | | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> | | 22c. DATE SIGNED
<i>2/9/82</i> | | | | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
<i>JOHN E GORDON</i> | | 9052 | | 22e. ADDRESS
<i>SINAI HOSP.</i> | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)
<i>Burial</i> | | 23b. DATE
<i>2-12-82</i> | | 23c. NAME OF CEMETERY OR CREMATORY
<i>Woodlawn Cemetery</i> | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
<i>Woodlawn Baltimore Maryland</i> | | | | | |
| 24. FUNERAL DIRECTOR
NAME
<i>Loring Byers Funeral Directors Inc.</i> | | ADDRESS
<i>8728 Liberty Road Randallstown, MD. 21133</i> | | 25a. DATE REC'D BY REGISTRAR
<i>FEB 11 1982</i> | | 25b. REGISTRAR'S SIGNATURE
<i>Thomas J. Martin</i> | | | | | |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

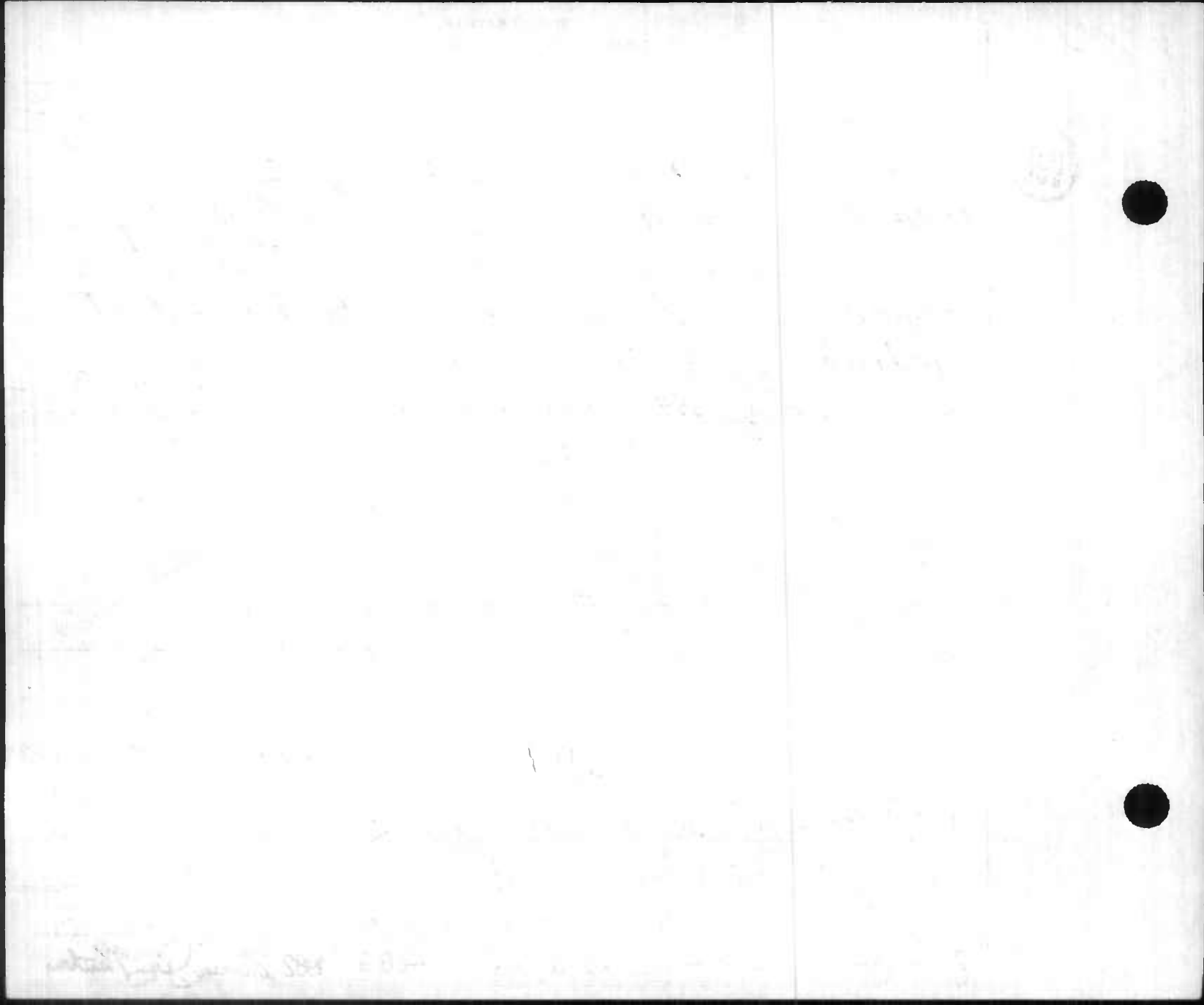
STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 2 0 3 9 0 2

FOR
1. STATE
REGISTRAR

REG. NO.

| | | | | | | | | | | | | |
|--|--|--|------------------------------|---|--|---|---|--|--|--|--|--|
| 1. DECEASED NAME
(TYPE OR PRINT)
PATRICK | | | FIRST MIDDLE LAST
KEATING | | | 2a. DATE OF DEATH
MONTH DAY YEAR
2-3-82 | | | 2b. HOUR
4:10 PM | | | |
| 3. SEX
MALE | | 4. RACE
WHITE | | 5. DATE OF BIRTH
MONTH DAY YEAR
11 18 25 | | | 6. AGE (IN YEARS LAST BIRTHDAY)
56 YRS. | | | IF UNDER 1 YEAR
MONTHS DAYS HOURS MIN. | | |
| 7. BIRTH PLACE (STATE OR FOREIGN COUNTRY)
Phila. Pa. | | 7b. CITIZEN OF WHAT COUNTRY?
USA | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | | 9. BALTIMORE CITY OR COUNTY OF DEATH
BALTO. City MD. | | | | | |
| 10. CITY OR TOWN OF DEATH
BALTO. | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
DUKELAND NRS HOME | | | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
Retired | | | 12b. KIND OF BUSINESS OR INDUSTRY | | | |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)
13a. STATE
Maryland | | | | | | 13b. COUNTY
BALTO. | | 13c. CITY OR TOWN
BALTO. | | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | |
| 14. FATHER'S NAME
PATRICK | | | | | | 15. MOTHER'S MAIDEN NAME
Margaret | | 16. STREET ADDRESS
1501 Dukeland St | | 17. ADDRESS
Phila. Pa. | | |
| 18a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN) YES | | | | | | 18b. SOCIAL SECURITY NO.
NAVY 194-15-7692 | | 19. INFORMANT
Mr. William Keating 3945 Duman St. | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY
IMMEDIATE CAUSE (a) ACUTE Respiratory Failure
4920
DUE TO, OR AS A CONSEQUENCE OF
(b) Severe Emphysema
DUE TO, OR AS A CONSEQUENCE OF
(c)
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
Yrs | | | | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)
Continued Cigarettes | | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | | |
| 21d. INJURY OCCURRED
WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 11/12, 1981, to 3 Feb, 1982, that (I) (we) last saw the deceased alive on 3 Feb, 1982, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did not) view the body after death. | | | | | | | | | | | | |
| 22b. SIGNATURE
Louis N. Randall MD | | | | | | DEGREE
MD | | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | 22c. DATE SIGNED
3 Feb. 82 | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
Louis N. RANDALL MD | | | | | | 22e. ADDRESS
2300 Garrison Blvd | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)
13 | | | | 23b. DATE
2/10/82 | | 23c. NAME OF CEMETERY OR CREMATORY
Holy Sepulchre | | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
Phila Pa | | | |
| 24. FUNERAL DIRECTOR
NAME
Joseph L. Burns | | | | | | ADDRESS
1222 W. York | | 25a. DATE REC'D. BY REGISTRAR
FEB 9 1982 | | 25b. REGISTRAR'S SIGNATURE
James J. Nathan | | |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours of death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

FOR
1 - STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 2 0 3 9 0 3

REG. NO.

| | | | | | | | | | |
|--|--|---|--|---|--|--|---|--|--|
| 1. DECEASED NAME
(TYPE OR PRINT)
MARGUERITE | | | 2a. DATE OF DEATH
MONTH DAY YEAR
FEBRUARY 20, 1982 | | | 2b. HOUR
3:40 P.M. | | | |
| 1. SEX
F | | 4. RACE
N | | 5. DATE OF BIRTH
MONTH DAY YEAR
6-19-1893 | | 6. AGE (IN YEARS LAST BIRTHDAY)
88 | | 7. IF UNDER 1 YEAR
MONTHS DAYS HOURS MIN.
YRS. | |
| 3. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
PENN | | 7b. CITIZEN OF WHAT COUNTRY?
USA | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
BALTIMORE CITY MD. | | | |
| 10. CITY OR TOWN OF DEATH
BALTIMORE | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
MARYLAND GENERAL HOSPITAL | | | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
Home Make | | 12b. KIND OF BUSINESS OR INDUSTRY
At Home | |
| 13a. STATE
MD | | | 13b. COUNTY
BALTO | | 13c. CITY OR TOWN
BALTIMORE | | 13d. INSIDE CITY LIMITS?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
Michael J Kellagher | | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
Margaret Brown | | | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN) No | | | |
| 16b. SOCIAL SECURITY NO. | | | 17. INFORMANT
Tam. Ly Records | | | ADDRESS | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART 1. DEATH WAS CAUSED BY:
5070 Aspiration Pneumonia
IMMEDIATE CAUSE (a) 5070
DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.
(b) _____
DUE TO, OR AS A CONSEQUENCE OF
(c) _____ | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)
Chronic Organic Brain Syndrome | | | | | | | | | |
| 19a. DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1b, PART 1 OR PART 2) | | | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/> | | | 21e. PLACE OF INJURY
(AT HOME STREET, FACTORY, OFFICE, FARM, ETC.) | | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | |
| 22a. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from January 4, 1982 to February 20, 1982 , that <input checked="" type="checkbox"/> (we) lost
saw the deceased alive on February 20, 1982 , and that in <input checked="" type="checkbox"/> (our) opinion death occurred on the date and hour and from the causes stated
above <input checked="" type="checkbox"/> (we) did <input checked="" type="checkbox"/> view the body after death. | | | | | | | | | |
| 22b. SIGNATURE
Huang-Ta Lin | | | | | DEGREE
M.D. | | | 22c. DATE SIGNED | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
HUANG-TA LIN, M.D. | | | | | 22e. ADDRESS
c/o MARYLAND GENERAL HOSPITAL | | | | |
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)
BURIAL | | | 23b. DATE
2/23/82 | | 23c. NAME OF CEMETERY OR CREMATORY
St. Joseph Cemetery | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
Louis Cap Mt Carmel PA | | |
| 24. FUNERAL DIRECTOR
NAME
EVAN'S FUNERAL CHAPEL | | | | | 25a. DATE REC'D. BY REGISTRAR
MAR 2 1982 | | | | |
| ADDRESS
8800 Hartford Rd | | | | | 25b. REGISTRAR'S SIGNATURE
Charles Jean Matthews | | | | |

RECEIVED

RECEIVED

RECEIVED

RECEIVED

RECEIVED

RECEIVED

RECEIVED

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 2 0 3 9 0 4

FOR
1. STATE
REGISTRAR

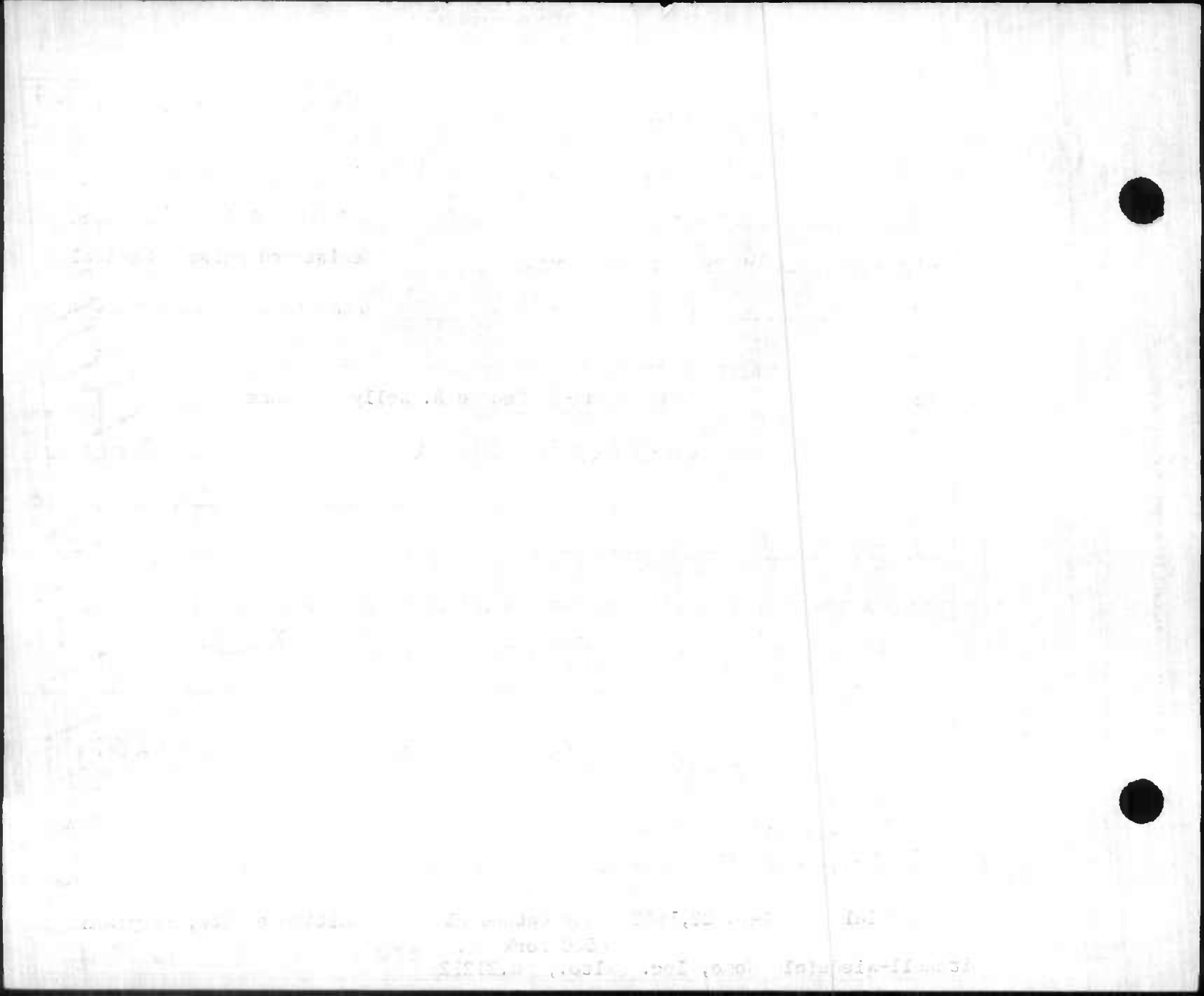
REG. NO.

| | | | | | |
|---|---|---|--|---|---|
| 1. DECEASED NAME
(TYPE OR PRINT)
FIRST MIDDLE LAST
Elizabeth EVA Kelly | | | 2a. DATE OF DEATH
MONTH DAY YEAR
FEB 18, 1982 | | 2b. HOUR
12:30 A M |
| 3. SEX
Female | 4. RACE
W | 5. DATE OF BIRTH
MONTH DAY YEAR
8 - 10 - 1900 | 6. AGE (IN YEARS LAST BIRTHDAY)
81 YRS. | IF UNDER 1 YEAR
MONTHS DAYS
IF UNDER 24 HRS.
HOURS MIN. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
ME. | 7b. CITIZEN OF WHAT COUNTRY?
U.S.A | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 9. BALTIMORE CITY OR COUNTY OF DEATH
Baltimore City MD. | | |
| 10. CITY OR TOWN OF DEATH
Baltimore | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
Union Memorial Hosp. | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
Registered Nurse | | 12b. KIND OF BUSINESS OR INDUSTRY
Medical |
| 13a. STATE
md. | | 13b. COUNTY | 13c. CITY OR TOWN
Bal. | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | 13e. STREET ADDRESS
4101 Loch Raven Blvd Apt 2 |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
Frank | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
Jordan | | Donnell | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
No | | 16b. SOCIAL SECURITY NO.
(IF YES, GIVE WAR OR DATES)
220 301468 | | 17. INFORMANT
George R. Kelly
ADDRESS
Same | |

| | | |
|---|--|--|
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) 7855 CARDIOGENIC SHOCK | | APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATH
3 hrs |
| DUE TO, OR AS A CONSEQUENCE OF
(b) | | |
| DUE TO, OR AS A CONSEQUENCE OF
(c) | | |

| | | | |
|--|--|--|---|
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (c). | | | |
| 19a. DATE OF OPERATION | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | 20b. IF YES, WERE FINDINGS USED
IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | |
| 21d. INJURY OCCURRED
WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | |
| 22. I certify that (I) (this hospital) attended the deceased from Feb 17 19 82, to Feb 18 19 82, that (I) (we) lost
saw the deceased alive on Feb 17 19 82, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated
above, (I) (we) (did) (did not) view the body after death. | | | |
| 22b. SIGNATURE
Richard A. Lebow | | DEGREE
M.D. | 22c. DATE SIGNED
02/18/82 |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
RICHARD A. Lebow | | 22e. ADDRESS
Union Memorial Hospital | |

| | | | |
|---|----------------------------|---|--|
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)
Burial | 23b. DATE
Feb. 22, 1982 | 23c. NAME OF CEMETERY OR CREMATORY
New Cathedral | 23d. LOCATION
CITY OR TOWN COUNTY STATE
Baltimore City, Maryland |
| 24. FUNERAL DIRECTOR
NAME
Mitchell-Wiedefeld Home, Inc. Balto., Md. 21212 | | 25a. DATE REC'D. BY REGISTRAR
FEB 19 1982 | 25b. REGISTRAR'S SIGNATURE
Shane J. Thornton |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the informant, page 3 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH | | | | REG. NO. 8 2 0 3 9 0 5 | |
|---|--|--|---|---|--|
| 1. FOR STATE REGISTRAR | | | | 2a. DATE OF DEATH MONTH 2 DAY 1 YEAR 82 2b. HOUR 20 | |
| 1. DECEASED NAME FIRST Hallie MIDDLE Davis LAST Kelly
<i>Hallie Kelly</i> | | | | 2b. DATE OF DEATH MONTH 2 DAY 1 YEAR 82 2b. HOUR 20
<i>2-1-82 12 A.M.</i> | |
| 3. SEX Female | 4. RACE White | 5. DATE OF BIRTH MONTH 3 DAY 14 YEAR 89 | 6. AGE (IN YEARS LAST BIRTHDAY) 92 YRS. | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Virginia | 7b. CITIZEN OF WHAT COUNTRY? USA | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 9. BALTIMORE CITY OR COUNTY OF DEATH City Baltimore City MD | | |
| 10. CITY OR TOWN OF DEATH Baltimore | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Lutheran Hospital | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Homemaker | | 12b. KIND OF BUSINESS OR INDUSTRY Housewife |
| 13a. STATE Maryland | | | | 13b. COUNTY Baltimore | |
| 13c. CITY OR TOWN Baltimore | | | | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 14. FATHER'S NAME FIRST Edgar MIDDLE LAST McFarland | | | | 15. MOTHER'S MAIDEN NAME FIRST Lavinia MIDDLE LAST Wyckoff | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No | | 16b. SOCIAL SECURITY NO. 218-48-1393 | | 17. INFORMANT ADDRESS Mrs. Anita A. Stoker, Baltimore, Md. 21228 | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART 1. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <i>Cardiorespiratory arrest</i>
<i>4273</i>
DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b) <i>Thrombo embolism</i>
DUE TO, OR AS A CONSEQUENCE OF
(c) <i>Arrhythmia</i> | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | |
| 22a. I certify that (I) (this hospital) attended the deceased from <i>1/31</i> , 19 <i>82</i> , to <i>2/1</i> , 19 <i>82</i> , that (I) (we) lost saw the deceased alive on above, (I) (we) (did) (did not) view the body after death. | | | | | |
| 22b. SIGNATURE <i>Dr. Henry Saceris</i> | | | | 22c. DATE SIGNED <i>2/1/82</i> | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) <i>Dr. Henry Saceris</i> | | | | 22e. ADDRESS <i>Lutheran Hospital of Maryland</i> | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | | 23b. DATE 2/3/82 | | 23c. NAME OF CEMETERY OR CREMATORY Western Cemetery | |
| 23d. LOCATION CITY OR TOWN Baltimore | | COUNTY | | STATE Md. | |
| 24. FUNERAL DIRECTOR NAME Witzke P.A. ADDRESS 1630 Edmondson Avenue, Catonsville, Md. 21228 | | | | 25a. DATE REC'D. BY REGISTRAR FEB 3 1982 | |
| | | | | 25b. REGISTRAR'S SIGNATURE <i>Thomas J. Martin</i> | |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

| STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH | | | | 8 2 0 3 9 0 6 | | | |
|--|--|---|--|--|--|---|--|
| 1 - FOR STATE REGISTRAR | | | | REG. NO. | | | |
| 1. DECEASED NAME (TYPE OR PRINT) LAST Kennedy , MIDDLE FIRST Bernard | | | | 2a. DATE OF DEATH MONTH DAY YEAR 2-19-82 | | 2b. HOUR 1010A | |
| 3 SEX Male | | 4. RACE White | | 5. DATE OF BIRTH MONTH DAY YEAR 11 15 21 | | 6. AGE (IN YEARS LAST BIRTHDAY) 60 YRS. IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Md. | | 7b. CITIZEN OF WHAT COUNTRY? U.S.A. | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH Balto. City MD | |
| 10. CITY OR TOWN OF DEATH Balto. | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) John L. Deaton Medical Center | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Clerk | | 12b. KIND OF BUSINESS OR INDUSTRY State Gov't | |
| 13a. STATE Md. | | 13b. COUNTY Balto. | | 13c. CITY OR TOWN Balto. | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 14. FATHER'S NAME FIRST MIDDLE LAST Bernard Kennedy, Sr. | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Mary Duffy | | 13e. STREET ADDRESS 1707 E. 25th St. | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) Yes | | 16b. SOCIAL SECURITY NO 215-12-8778 | | 17. INFORMANT ADDRESS Margaret Kennedy Balto., Md. | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) RESPIRATORY ARREST | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | | |
| 1599 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last | | | | (b) GASTROINTESTINAL CANCER | | | |
| | | | | (c) METASTASIS of CANCER | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 21c. PART 1 OR PART 2) | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | |
| 22a. I certify that (1) this hospital attended the deceased from FEB. 14 19 82 to FEB. 19 19 82 , that (1) (we) last saw the deceased alive on FEB. 14 19 82 and that in my (our) opinion death occurred on the date and hour and from the causes stated above (1) (we) (did) (did not) view the body after death. | | | | | | | |
| 22b. SIGNATURE Winthrop C. Davis, MD DEGREE | | | | 22c. DATE SIGNED 2/19/82 | | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) Winthrop C. Davis, MD | | | | 22e. ADDRESS J.L. Deaton, 611 CHAS. ST., BALT., MD. | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Removal | | 23b. DATE 2/19/82 | | 23c. NAME OF CEMETERY OR CREMATORY | | 23d. LOCATION CITY OR TOWN COUNTY STATE | |
| 24. FUNERAL DIRECTOR NAME Anatomy Board ADDRESS Balto., Md. | | | | 25a. DATE REC'D. BY REGISTRAR FEB 26 1982 | | 25b. REGISTRAR'S SIGNATURE <i>[Signature]</i> | |

Page 1

1. The first of the three main parts of the report is a general survey of the situation in the country. This part is divided into three sections: (a) the political situation, (b) the economic situation, and (c) the social situation. The second part of the report is a detailed study of the political situation. This part is divided into two sections: (a) the political system, and (b) the political parties. The third part of the report is a detailed study of the economic situation. This part is divided into two sections: (a) the economic system, and (b) the economic problems. The fourth part of the report is a detailed study of the social situation. This part is divided into two sections: (a) the social system, and (b) the social problems. The fifth part of the report is a summary of the findings of the study. This part is divided into two sections: (a) the conclusions, and (b) the recommendations. The sixth part of the report is a list of references. This part is divided into two sections: (a) the books, and (b) the articles. The seventh part of the report is a list of appendices. This part is divided into two sections: (a) the maps, and (b) the tables. The eighth part of the report is a list of footnotes. This part is divided into two sections: (a) the footnotes, and (b) the endnotes. The ninth part of the report is a list of indexes. This part is divided into two sections: (a) the subject index, and (b) the author index. The tenth part of the report is a list of errata. This part is divided into two sections: (a) the errata, and (b) the corrections.

Page 1

Page 1

Page 1

Page 1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of this.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 2 0 3 9 0 7

| | | | |
|---|--|--|--|
| 1. FOR STATE REGISTRAR | | REG. NO. | |
| 1. DECEASED NAME
(TYPE OR PRINT)
FIRST MIDDLE LAST
HUGH F. KENNEDY | | 2a. DATE OF DEATH
MONTH DAY YEAR
2 9 82
2b. HOUR
7 4 A M | |
| 3. SEX
Male | 4. RACE
White | 5. DATE OF BIRTH
MONTH DAY YEAR
Aug. 31, 1902 | |
| 6a. BIRTHPLACE
(STATE OR FOREIGN COUNTRY)
Baltimore | 7b. CITIZEN OF WHAT COUNTRY?
USA | 8. AGE (IN YEARS LAST BIRTHDAY)
79 YRS. | |
| 10. CITY OR TOWN OF DEATH
Baltimore | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
Union Memorial Hospital | 9. BALTIMORE CITY OR COUNTY OF DEATH
Baltimore City MD. | |
| 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
Carpenter | | 12b. KIND OF BUSINESS OR INDUSTRY
Carpentry | |
| 13a. STATE
Maryland | | 13b. COUNTY | 13c. CITY OR TOWN
Baltimore |
| 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS
5006 York Road | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
Hugh Kennedy | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
Elizabeth Murphy | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
No | | 16b. SOCIAL SECURITY NO.
(IF YES, GIVE WAR OR DATES)
047 09 9716 | 17. INFORMANT
ADDRESS
Mary Brooks, Balto., Md. |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART 1. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>Sepsis</u>
DUE TO, OR AS A CONSEQUENCE OF
(b) <u>Renal failure</u>
DUE TO, OR AS A CONSEQUENCE OF
(c) _____
5860 | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a): | | | |
| 19a. DATE OF OPERATION | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER NOTIFY MEDICAL EXAMINER) | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | |
| 21d. INJURY OCCURRED
WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>2/9</u> , 19 <u>82</u> , to <u>2/9</u> , 19 <u>82</u> , that (I) (we) last saw the deceased alive on <u>2/9</u> , 19 <u>82</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death. | | | |
| 22b. SIGNATURE
<u>Brian H. Kah</u> | | DEGREE
<u>M.D.</u> | 22c. DATE SIGNED
<u>2/9/82</u> |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
BRADY H. KAHN M.D. | | 22e. ADDRESS
UNION MEMORIAL HOSPITAL | |
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)
Burial | 23b. DATE
2/12/82 | 23c. NAME OF CEMETERY OR CREMATORY
New Cathedral | 23d. LOCATION
CITY OR TOWN COUNTY STATE
Balto., Md. |
| 24. FUNERAL DIRECTOR
NAME
Henry W. Jenkins & Sons Co.
4905 York Road Balto., Md. 21212 | | 25. DATE REC'D. BY REGISTRAR
FEB 11 1982 | |



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STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 2 0 3 9 0 8

REG. NO.

| | | | | | | | | | |
|--|--|---|--|---|--|--|--|--|--|
| 1. FOR
STATE
REGISTRAR | | 1. DECEASED NAME
(TYPE OR PRINT) | | FIRST MARY MIDDLE KENNEY LAST | | 2a. DATE OF DEATH MONTH DAY YEAR
2-10-82 | | 2b. HOUR
12:29P
M | |
| 3 SEX
Female | | 4 RACE
White | | 5. DATE OF BIRTH
MONTH DAY YEAR
Feb. 22 1933 | | 6. AGE (IN YEARS LAST BIRTHDAY)
48
YRS. | | IF UNDER 1 YEAR
MONTHS DAYS
IF UNDER 24 HRS.
HOURS MIN. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
South Carolina | | 7b. CITIZEN OF WHAT COUNTRY?
USA | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
Baltimore City
MD. | | | |
| 10. CITY OR TOWN OF DEATH
Baltimore | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN STATE, GIVE CITY AND STATE)
Johns Hopkins Hospital | | | | 12a. OPERATOR
(TYPE OF WORK FOR MOST OF WORKING LIFE)
Sewing Machine | | 12b. KIND OF BUSINESS OR INDUSTRY
Clothing Mfg. | |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) | | | | | | | | | |
| 13a. STATE
Md. | | 13b. COUNTY
Harford | | 13c. CITY OR TOWN
Edgewood | | 13d. INSIDE CITY LIMITS?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 13e. STREET ADDRESS
30001 Pulaski Hiway 21040 | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
Perry Culder | | | | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
Mamie | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
No | | 16b. SOCIAL SECURITY NO.
(IF YES, GIVE WAR OR DATES)
- | | 17. INFORMANT
ADDRESS
Charles Kenney, Husband S ₂ me | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART 1. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>cardiopulmonary arrest</u>
5712 DUE TO, OR AS A CONSEQUENCE OF
(b) <u>hepatic failure</u>
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO, OR AS A CONSEQUENCE OF
(c) <u>Laemmer's cirrhosis</u> | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a):
<u>renal failure sepsis</u> | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
12:29 PM 2 10 1982 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | | | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK AT WORK | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>12/11</u> 19 <u>81</u> to <u>2/10</u> 19 <u>82</u> , that (I) (we) lost
saw the deceased alive on <u>2/10/82</u> 19 <u>82</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated
above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | |
| 22b. SIGNATURE
<u>Oliver Ogelschke</u> | | | | | | DEGREE
ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> | | 22c. DATE SIGNED
<u>2/10/82</u> | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
<u>Oliver S. Schaw</u> | | | | | | 22e. ADDRESS | | | |
| 23a. BURIAL, CREMATION, REMOVAL
(SEE INSTRUCTIONS) | | 23b. DATE
<u>2/12/82</u> | | 23c. NAME OF CEMETERY OR CREMATORY
<u>Meadowridge Memorial Park</u> | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
<u>Howard Co., Md.</u> | | | |
| 24. FUNERAL DIRECTOR
<u>Bruzdzinski Funeral Home</u> | | | | | | 25a. DATE REC'D. BY REGISTRAR
<u>FEB 11 1982</u> | | | |
| 25b. REGISTRAR'S SIGNATURE
<u>James J. McArthur</u> | | | | | | | | | |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the death certificate with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of any.



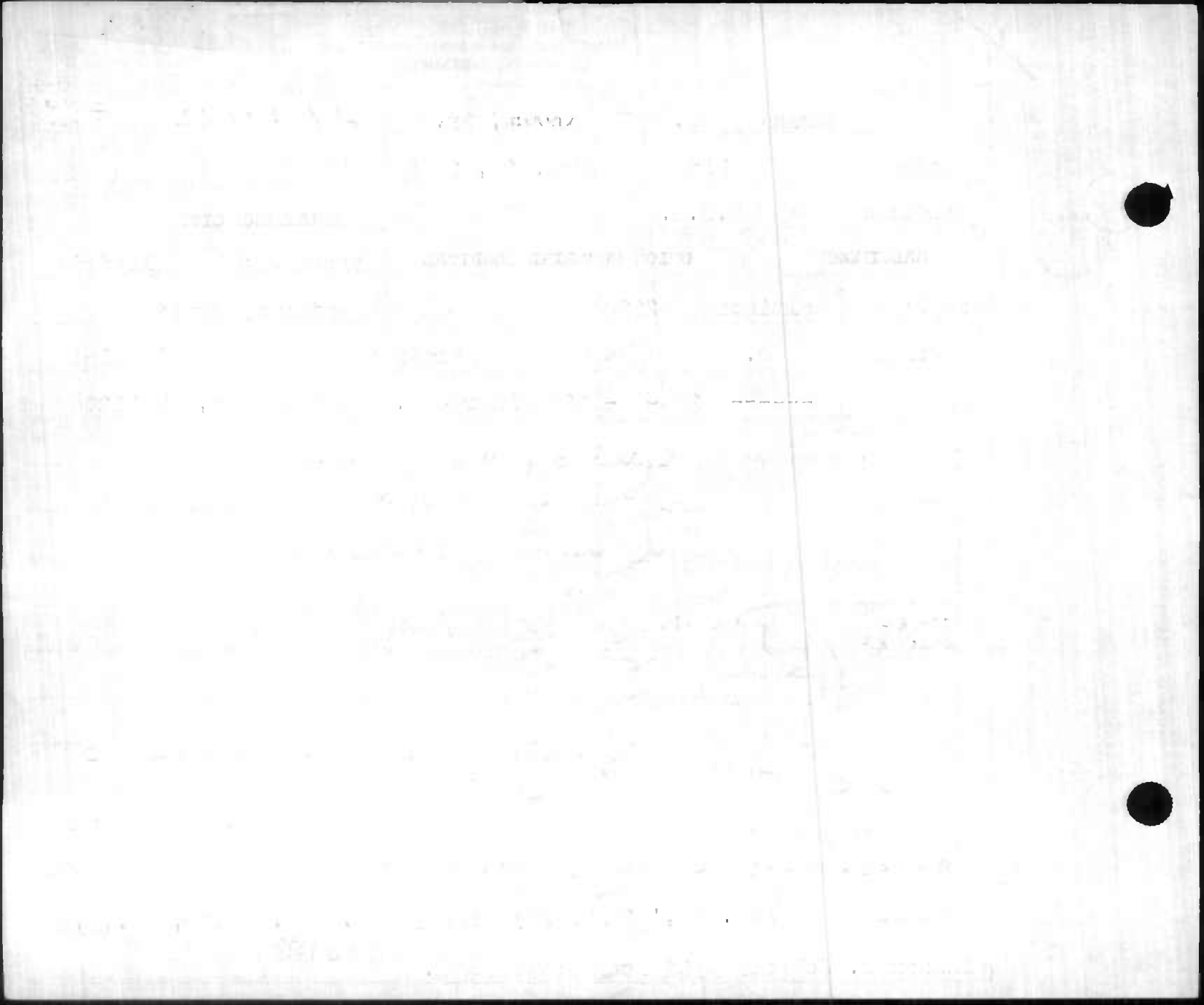
TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be retained by the funeral director. Pages 3 and 4 should be retained by the funeral director. Pages 5 and 6 should be retained by the funeral director. Pages 7 and 8 should be retained by the funeral director. Pages 9 and 10 should be retained by the funeral director. Pages 11 and 12 should be retained by the funeral director. Pages 13 and 14 should be retained by the funeral director. Pages 15 and 16 should be retained by the funeral director. Pages 17 and 18 should be retained by the funeral director. Pages 19 and 20 should be retained by the funeral director. Pages 21 and 22 should be retained by the funeral director. Pages 23 and 24 should be retained by the funeral director. Pages 25 and 26 should be retained by the funeral director. Pages 27 and 28 should be retained by the funeral director. Pages 29 and 30 should be retained by the funeral director. Pages 31 and 32 should be retained by the funeral director. Pages 33 and 34 should be retained by the funeral director. Pages 35 and 36 should be retained by the funeral director. Pages 37 and 38 should be retained by the funeral director. Pages 39 and 40 should be retained by the funeral director. Pages 41 and 42 should be retained by the funeral director. Pages 43 and 44 should be retained by the funeral director. Pages 45 and 46 should be retained by the funeral director. Pages 47 and 48 should be retained by the funeral director. Pages 49 and 50 should be retained by the funeral director. Pages 51 and 52 should be retained by the funeral director. Pages 53 and 54 should be retained by the funeral director. Pages 55 and 56 should be retained by the funeral director. Pages 57 and 58 should be retained by the funeral director. Pages 59 and 60 should be retained by the funeral director. Pages 61 and 62 should be retained by the funeral director. Pages 63 and 64 should be retained by the funeral director. Pages 65 and 66 should be retained by the funeral director. Pages 67 and 68 should be retained by the funeral director. Pages 69 and 70 should be retained by the funeral director. Pages 71 and 72 should be retained by the funeral director. Pages 73 and 74 should be retained by the funeral director. Pages 75 and 76 should be retained by the funeral director. Pages 77 and 78 should be retained by the funeral director. Pages 79 and 80 should be retained by the funeral director. Pages 81 and 82 should be retained by the funeral director. Pages 83 and 84 should be retained by the funeral director. Pages 85 and 86 should be retained by the funeral director. Pages 87 and 88 should be retained by the funeral director. Pages 89 and 90 should be retained by the funeral director. Pages 91 and 92 should be retained by the funeral director. Pages 93 and 94 should be retained by the funeral director. Pages 95 and 96 should be retained by the funeral director. Pages 97 and 98 should be retained by the funeral director. Pages 99 and 100 should be retained by the funeral director.

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1STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 2 0 3 9 0 9

| | | | | | | | | | | | |
|--|---|---|--------|--|--|---|--|------------------|-----------------|--|--|
| 1. DECEASED NAME
(TYPE OR PRINT) | | FIRST | MIDDLE | LAST | 2a. DATE OF DEATH | | MONTH | DAY | YEAR | 2b. HOUR | |
| GERARD G. KEOGH, Sr. | | | | | 2/24/82 | | | | | 7:40 AM | |
| 3. SEX | 4. RACE | 5. DATE OF BIRTH | | | 6. AGE (IN YEARS LAST BIRTHDAY) | | IF UNDER 1 YEAR | | IF UNDER 24 HRS | | |
| Male | White | Feb. 19, 1906 | | | 76 | | | | | | |
| 7. BIRTHPLACE
(STATE OR FOREIGN COUNTRY) | 7b. CITIZEN OF WHAT COUNTRY? | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | | 9. BALTIMORE CITY OR COUNTY OF DEATH | | | MD. | | | |
| Maryland | U.S.A. | | | | BALTIMORE CITY | | | | | | |
| 10. CITY OR TOWN OF DEATH | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) | | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE) | | | 12b. KIND OF BUSINESS OR INDUSTRY | | | | |
| BALTIMORE | UNION MEMORIAL HOSPITAL | | | Management | | | Electric | | | | |
| 13a. STATE | | 13b. CITY OR TOWN | | 13c. INSIDE CITY LIMITS? | | 13d. STREET ADDRESS | | | | | |
| Maryland | | Baltimore | | 21204 | | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 4 Waterway Court | | | |
| 14. FATHER'S NAME | | 15. MOTHER'S MAIDEN NAME | | | | | | | | | |
| James J. Keogh | | Margaret Gibblin | | | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN) | | 16b. SOCIAL SECURITY NO. | | 17. INFORMANT ADDRESS | | | | | | | |
| No | | 166-05-1129 | | Mildred V. Keogh Towson, MD 21204 | | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c):
PART 1. DEATH WAS CAUSED BY:
4360 IMMEDIATE CAUSE (a) <u>Cardio pulmonary arrest</u>
DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last
(b) <u>2nd to CVA</u>
DUE TO, OR AS A CONSEQUENCE OF
(c) <u>advanced ASVD</u> | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)
<u>See above</u> | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY? | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? | | | | |
| 2/19/82
2/18/82 | | ASVD for profundoplasty | | | YES <input type="checkbox"/> NO <input type="checkbox"/> | | YES <input type="checkbox"/> NO <input type="checkbox"/> | | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | | | | | |
| 21d. INJURY OCCURRED
WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>2/15/1982</u> , to <u>2/24/1982</u> , that (we) lost
saw the deceased alive on <u>2/23/1982</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated
above. (We) (did) not view the body after death. | | | | | | | | | | | |
| 22b. SIGNATURE
<u>A. HAZARIAN</u> | | | | | DEGREE
ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> | | 22c. DATE SIGNED
2/24/82 | | | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
AGHAZARIAN SARKIS | | | | | 22e. ADDRESS
UNION MEMORIAL HOSPITAL | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL
(TYPE) | | 23b. DATE | | 23c. NAME OF CEMETERY OR CREMATORY | | 23d. LOCATION
CITY OR TOWN COUNTY STATE | | | | | |
| Burial | | Feb. 27, '82 | | Dulaney Valley Mem. Gar. Balto | | Co. Md. | | | | | |
| 24. FUNERAL DIRECTOR
NAME ADDRESS | | | | | 25a. DATE REC'D BY REGISTRAR
25b. REGISTRAR'S SIGNATURE | | | | | | |
| William E. Johnson 8521 Loch Raven Blvd. | | | | | FEB 26 1982 | | | | | | |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled within 7 days of death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 2 0 3 9 1 0

REG. NO.

| | | | | | |
|---|---|--|--|---|--|
| 1. DECEASED NAME
(TYPE OR PRINT)
FIRST MIDDLE LAST
Mary R. KIDD | | | 2a. DATE OF DEATH
MONTH DAY YEAR
February 26, 1982 | | 2b. HOUR
9:54a M |
| 3. SEX
Female | 4. RACE
white | 5. DATE OF BIRTH
MONTH DAY YEAR
8/30/96 | | 6. AGE (IN YEARS LAST BIRTHDAY)
85 YRS. | IF UNDER 1 YEAR
MONTHS DAYS
IF UNDER 24 HRS.
HOURS MIN. |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
Maryland | 7b. CITIZEN OF WHAT COUNTRY?
USA | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
Baltimore City MD. | |
| 10. CITY OR TOWN OF DEATH
Baltimore | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
Maryland General Hospital | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
Chemist | | 12b. KIND OF BUSINESS OR INDUSTRY
Papermill |
| 13a. STATE
Md | | 13b. COUNTY | 13c. CITY OR TOWN
Baltimore | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | 13e. STREET ADDRESS
1802 Eutaw Place |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
William C. Kidd | | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
Agnes Loretta Meeker | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES OR UNKNOWN) NO | | 16b. SOCIAL SECURITY NO.
217 26 5186 | | 17. INFORMANT ADDRESS
Edward Kidd PO Box 99 Barton, Md 21521 | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART 1. DEATH WAS CAUSED BY:
4100 Myocardial Infarction
IMMEDIATE CAUSE (a)
DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b)
DUE TO, OR AS A CONSEQUENCE OF
(c) | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | |
| 21d. INJURY OCCURRED
WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | |
| 22a. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from February 26, 1982 to February 26, 1982 , that <input checked="" type="checkbox"/> (we) lost <input type="checkbox"/> saw the deceased alive on above, (b) we (did) <input checked="" type="checkbox"/> view the body after death. | | | | | |
| 22b. SIGNATURE
Harry E. Nervino, M.D. | | DEGREE
M.D. | | 22c. DATE SIGNED
2/26/82 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
Harry Nervino, M.D. | | 22e. ADDRESS
c/o Maryland General Hospital | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)
Burial | | 23b. DATE
3/2/82 | 23c. NAME OF CEMETERY OR CREMATORY
New Cathedral Cem. | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
Baltimore, Maryland |
| 24. FUNERAL DIRECTOR
Burgee Funeral Home 3631 Falls Road 21211 | | | 25a. DATE REC'D. BY REGISTRAR
MAR 2 1982 | | |

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Dear Sir,

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TO HOSPITAL OR ATTENDING PHYSICIAN. The law requires that the death certificate be executed within 24 hours after death. Part 2 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 7 days after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

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1 - FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 2 0 3 1 1

REG. NO.

| | | | | | | | |
|--|--|--|--|---|--|--|--|
| 1. DECEASED NAME
(TYPE OR PRINT)
John Francis Kiley, Jr. | | | 2a. DATE OF DEATH
MONTH DAY YEAR
2 16 82 | | | 2b. HOUR
2 AM | |
| 3. SEX
Male | | 4. RACE
White | | 5. DATE OF BIRTH
MONTH DAY YEAR
1 5 29 | | 6. AGE (IN YEARS LAST BIRTHDAY)
53 YRS. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
N. Jersey | | 7b. CITIZEN OF WHAT COUNTRY?
USA | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
Baltimore City MD. | |
| 10. CITY OR TOWN OF DEATH
Baltimore | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
Good Samaritan Hospital | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
Sales | | 12b. KIND OF BUSINESS OR INDUSTRY
Health Care | |
| 13a. STATE
Md. | | 13b. COUNTY
Balto. | | 13c. CITY OR TOWN
Cockeysville | | 13d. INSIDE CITY LIMITS?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
John F. Kiley, Sr. | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
Irene C. Smith | | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN) [IF YES, GIVE WAR OR DATES]
No --- | | | |
| 16b. SOCIAL SECURITY NO.
149-20-1698 | | 17. INFORMANT ADDRESS
Mrs. Jane M. Kiley, 10706 Cardington Pl. | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART 1. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>cardiopulmonary failure / renal failure</u>
2500
DUE TO, OR AS A CONSEQUENCE OF:
(b) <u>diabetes</u>
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last
(c) _____
DUE TO, OR AS A CONSEQUENCE OF _____ | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: _____ | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | |
| 21d. INJURY OCCURRED
WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>2/11</u> , 19 <u>82</u> , to <u>2/16</u> , 19 <u>82</u> , that (I) (we) last saw the deceased alive on <u>2/15</u> , 19 <u>82</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (do not) view the body after death. | | | | | | | |
| 22b. SIGNATURE
D. Margulies MD | | | | DEGREE
ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> | | 22c. DATE SIGNED
2/16/82 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
MARGULIES MD. | | | | 22e. ADDRESS
Good Samaritan Hospital, Baltimore | | | |
| 23a. BURIAL, CREMATION, REMOVAL
Burial | | 23b. DATE
2/18/82 | | 23c. NAME OF CEMETERY OR CREMATORY
St. John's Ch. Cem. | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
Long Green, Maryland | |
| 24. FUNERAL DIRECTOR
Lemmon-Mitchell-Wiedefeld, 10 W. Padonia | | | | 25a. DATE REC'D. BY REGISTRAR
FEB 17 1982 | | 25b. REGISTRAR'S SIGNATURE
Charles Jean Nathan | |



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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

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| STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH | | | | | | | | | | 8 2 0 3 9 1 2 | |
|---|--|--|--|--|--|--|--|--|--|---------------|--|
| 1. FOR
STATE
REGISTRAR | | REG. NO. | | | | | | | | | |
| 1. DECEASED NAME
(TYPE OR PRINT)
FIRST MIDDLE LAST
RUFUS B. KILLEN | | | | | | 2a. DATE OF DEATH
MONTH DAY YEAR
2-18-82 | | 2b. HOUR
MIN
1:09 PM | | | |
| 3. SEX
Male | | 4. RACE
White | | 5. DATE OF BIRTH
MONTH DAY YEAR
1 15 1890 | | 6. AGE (IN YEARS LAST BIRTHDAY)
YRS
92 | | IF UNDER 1 YEAR
MONTHS DAYS
IF UNDER 24 HRS
HOURS MIN | | | |
| 7a. BIRTHPLACE
(STATE OR FOREIGN COUNTRY)
Kentucky | | 7b. CITIZEN OF WHAT COUNTRY?
U.S.A. | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
Balto. City MD. | | | | | |
| 10. CITY OR TOWN OF DEATH
Baltimore | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
Good Samaritan Hosp. | | | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
Lumberman | | 12b. KIND OF BUSINESS OR INDUSTRY
Lumber | | | |
| 13a. STATE
MD | | 13b. COUNTY
21205 | | 13c. CITY OR TOWN
Baltimore | | 13d. INSIDE CITY LIMITS?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS
935 ALDRICKS LANE | | | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
Floyd Killen | | | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
Lucinda Holbrooks | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
No | | | | 16b. SOCIAL SECURITY NO.
(IF YES, GIVE WAR OR DATES)
226-18-5173 | | 17. INFORMANT
ADDRESS
Thurman Killen Pound, Virginia | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART 1. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) CARDIORESPIRATORY ARREST
4280
DUE TO, OR AS A CONSEQUENCE OF
(b) PULMONARY EDEMA
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(c) CONGESTIVE HEART FAILURE | | | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: no | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1B, PART 1 OR PART 2) | | | | | | | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | | | | | |
| 22. I certify that (I) (this hospital) attended the deceased from 1-13-1982 to 2-18-1982 that (I) (we) last saw the deceased alive on 2-18-1982 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | | | |
| 27b. SIGNATURE
Lawson | | | | DEGREE
M.D. ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> | | | | 27c. DATE SIGNED | | | |
| 27d. PHYSICIAN'S NAME (TYPE OR PRINT)
ZAW MIN | | | | 27e. ADDRESS
5601 LOCH RAVEN BLVD, BALT. | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)
Burial | | 23b. DATE
Feb. 21, '82 | | 23c. NAME OF CEMETERY OR CREMATORY
Powell Valley Mem. | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
Big Stone Gap., VA | | | | | |
| 24. FUNERAL DIRECTOR
NAME
William E. Johnson | | | | ADDRESS
8521 Loch Raven Blvd. | | 25a. DATE RECD. BY REGISTRAR
FEB 22 1982 | | 25b. REGISTRAR'S SIGNATURE
Thane Jan... | | | |

THE UNIVERSITY OF
TORONTO LIBRARY
130 St. George Street
Toronto, Ontario M5S 1A5

5-12-5
M. D. M.
For the University of Toronto
M. D. M.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial/transfer permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

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| STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH | | | | | | | | | |
|---|--|--|--|---|--|---|--|--|--|
| 1. FOR STATE REGISTRAR | | | | | | | | | |
| 1. DECEASED NAME
(TYPE OR PRINT)
FIRST MIDDLE LAST
SARA C. KING | | | | | | 2a. DATE OF DEATH
MONTH DAY YEAR
2 1 1982 | | 2b. HOUR
M
AM | |
| 3. SEX
Female | | 4. RACE
White | | 5. DATE OF BIRTH
MONTH DAY YEAR
OCT. 4, 1912 | | 6. AGE (IN YEARS LAST BIRTHDAY)
YRS.
69 | | IF UNDER 1 YEAR
MONTHS DAYS
IF UNDER 24 HRS.
HOURS MIN. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
MARYLAND | | 7b. CITIZEN OF WHAT COUNTRY?
USA | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
BALTIMORE CITY MD. | | | |
| 10. CITY OR TOWN OF DEATH
BALTIMORE | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
3547 Greenmount Ave. | | | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
SUPERVISOR | | 12b. KIND OF BUSINESS OR INDUSTRY
DEPT. OF MOTOR VEHICLES | |
| 13a. STATE
MD. | | 13b. COUNTY | | 13c. CITY OR TOWN
BALTIMORE | | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS
3547 GREEN MOUNT AVE. 21218 | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
CHARLES MOUERY | | | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
IDA TERESA CUCIC | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
YES | | 16b. SOCIAL SECURITY NO.
(IF YES, GIVE WAR OR DATES)
WW2 | | 17. INFORMANT ADDRESS
MISS. DEBORAH L. MALLOTT 3547 GREEN MOUNT AVE | | | | | |
| 18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)
PART 1. DEATH WAS CAUSED BY
IMMEDIATE CAUSE (a) Cardiac Arrest
1629
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last
(b) Terminal Metastatic Lung Carcinoma
(c) Cigarette Smoking
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
5 mins
57 years
30 years | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)
Fell from Bed after arrest | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | | | |
| 21d. INJURY OCCURRED
WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY
(AT HOME STREET FACTORY OFFICE FARM ETC) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | | | |
| 22a. I certify that (I) (the hospital) attended the deceased from 1-23 , 19 82 to 1-23 , 19 82 , that (I) (we) last saw the deceased alive on 1-23-82 , 19 82 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did not) view the body after death. | | | | | | | | | |
| 22b. SIGNATURE
J.W. ZEBLEY M.D. | | | | DEGREE
ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | | | 22c. DATE SIGNED
2/82 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
J.W. ZEBLEY M.D. | | | | 22e. ADDRESS
3809 GREENMOUNT AVE. BALTIMORE, MD. 21218 | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)
BURIAL | | 23b. DATE
FEB. 5, 1982 | | 23c. NAME OF CEMETERY OR CREMATORY
BALTIMORE NATIONAL | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
BALTIMORE MD. | | | |
| 24. FUNERAL DIRECTOR
NAME ADDRESS
MITCHELL-WIEDEFELD HOME 6500 YORK RD. 21212 | | | | 25a. DATE REC'D BY REGISTRAR
FEB 8 1982 | | | | | |
| | | | | 25b. REGISTRAR'S SIGNATURE
<i>[Signature]</i> | | | | | |

8 B

8 2 0 3 9 1 3

0903 BP



Items 8,13a-13e,15 per phone

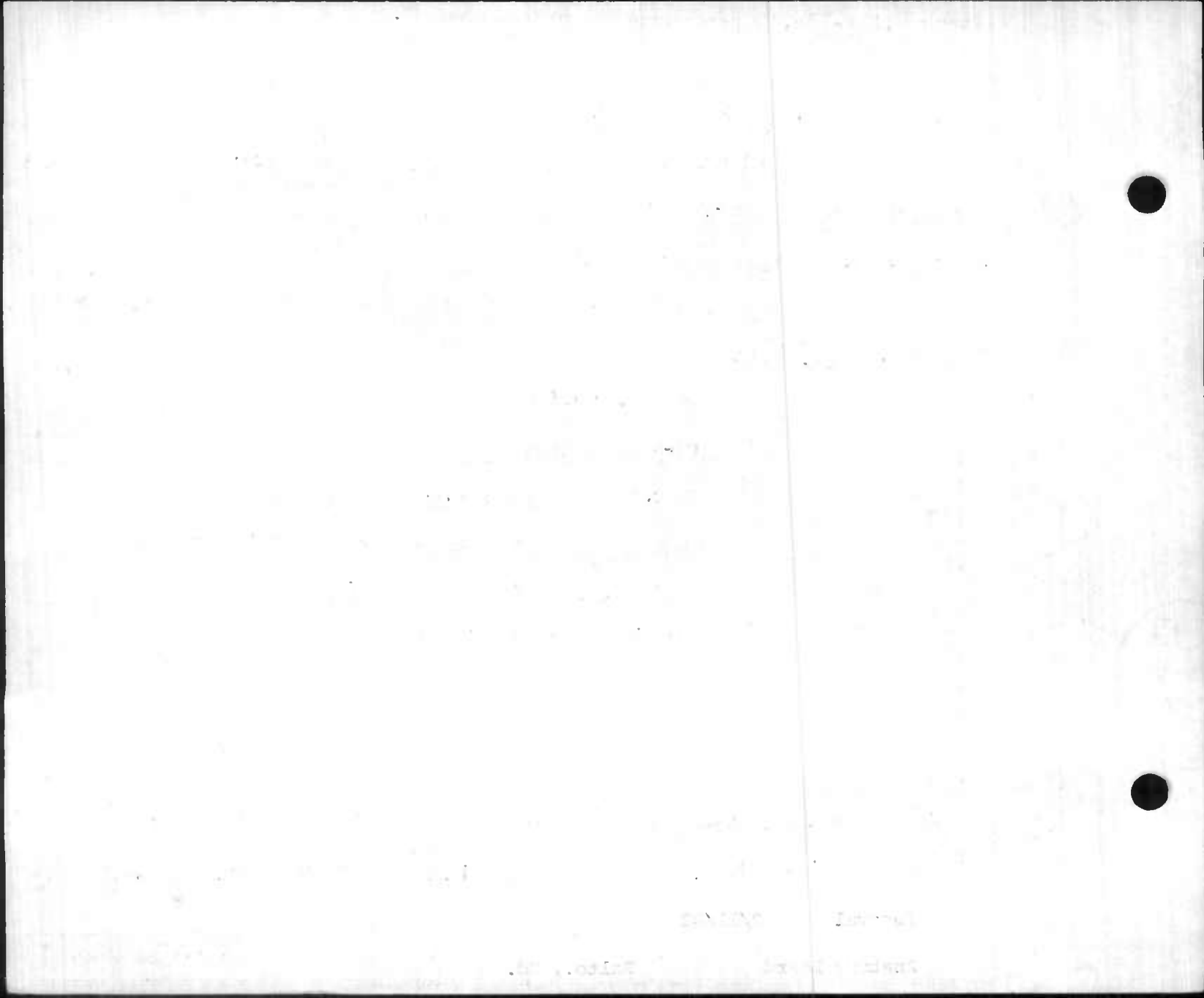
1. STATE
FOR
3/2/82 dad
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 2 0 3 9 1 4

REG. NO.

| | | | | | | | | | |
|---|--|--|--|---|---|---|--|--|--|
| 1. DECEASED NAME
(TYPE OR PRINT)
ETHEL BO KINGWOOD | | | 2a. DATE OF DEATH
MONTH DAY YEAR
2 2 82 | | | 2b. HOUR
12 ^{PM} | | | |
| 3 SEX
F | | 4 RACE
BLACK | | 5. DATE OF BIRTH
MONTH DAY YEAR
2 2 82 | | 6. AGE (IN YEARS LAST BIRTHDAY)
New BORN YRS. | | IF UNDER 1 YEAR
MONTHS DAYS
- 40 | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
BALTIMORE | | 7b. CITIZEN OF WHAT COUNTRY?
U.S.A | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
CITY MD. | | | |
| 10. CITY OR TOWN OF DEATH
BALTIMORE | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
PROVIDENT HOSP INC. | | | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE) | | 12b. KIND OF BUSINESS OR INDUSTRY | |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) | | | | | | | | | |
| 13a. STATE
Md. | | 13b. COUNTY | | 13c. CITY OR TOWN
Balto. | | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS
2308 Winchester St. 21216 | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
Goodie, John | | | | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
Ethel Kingwood | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN) | | | 16b. SOCIAL SECURITY NO.
(IF YES, GIVE WAR OR DATES)
213-62-4309 | | | 17. INFORMANT
ADDRESS | | | |

| | | | | | | | | | |
|--|--|--|---|--|------------------------------------|--|--|---|--|
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>HYPOVOLEMIA</u>
7650
DUE TO, OR AS A CONSEQUENCE OF
(b) <u>SEVERE PERINATAL ASPHYXIA</u>
DUE TO, OR AS A CONSEQUENCE OF
(c) <u>PREMATURITY ÷ 26 weeks gestation</u> | | | | | | | | APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATH | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)
<u>SEVERE ANTEPARTUM HEMORRHAGE in MOTHER</u> | | | | | | | | | |
| 19a. DATE OF OPERATION
C-SECTION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED
ANTEPARTUM HEMORRHAGE | | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED
IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | |
| 21d. INJURY OCCURRED
WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>2-2-82 12⁴⁰ PM</u> , to <u>2-2-82 1¹⁹ PM</u> , that (I) (we) lost
saw the deceased alive on <u>19</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated
above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | |
| 22b. SIGNATURE
<u>She Adeleye MD</u> | | | | | | DEGREE
MD | | 22c. DATE SIGNED
2-2-82 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
ETHEL A. ADELOYE MD | | | | | | 22e. ADDRESS
DEPT OF PEDIATRICS
PROVIDENT HOSP. INC. BALTIMORE | | | |
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)
Removal | | | 23b. DATE
2/11/82 | | 23c. NAME OF CEMETERY OR CREMATORY | | 23d. LOCATION
CITY OR TOWN COUNTY STATE | | |
| 24. FUNERAL DIRECTOR
NAME
Anatomy Board | | | | | | ADDRESS
Balto., Md. | | 25a. DATE REC'D. BY REGISTRAR
FEB 4 5 1982 | |
| 25b. REGISTRAR'S SIGNATURE
<u>Rose Jan...</u> | | | | | | | | | |

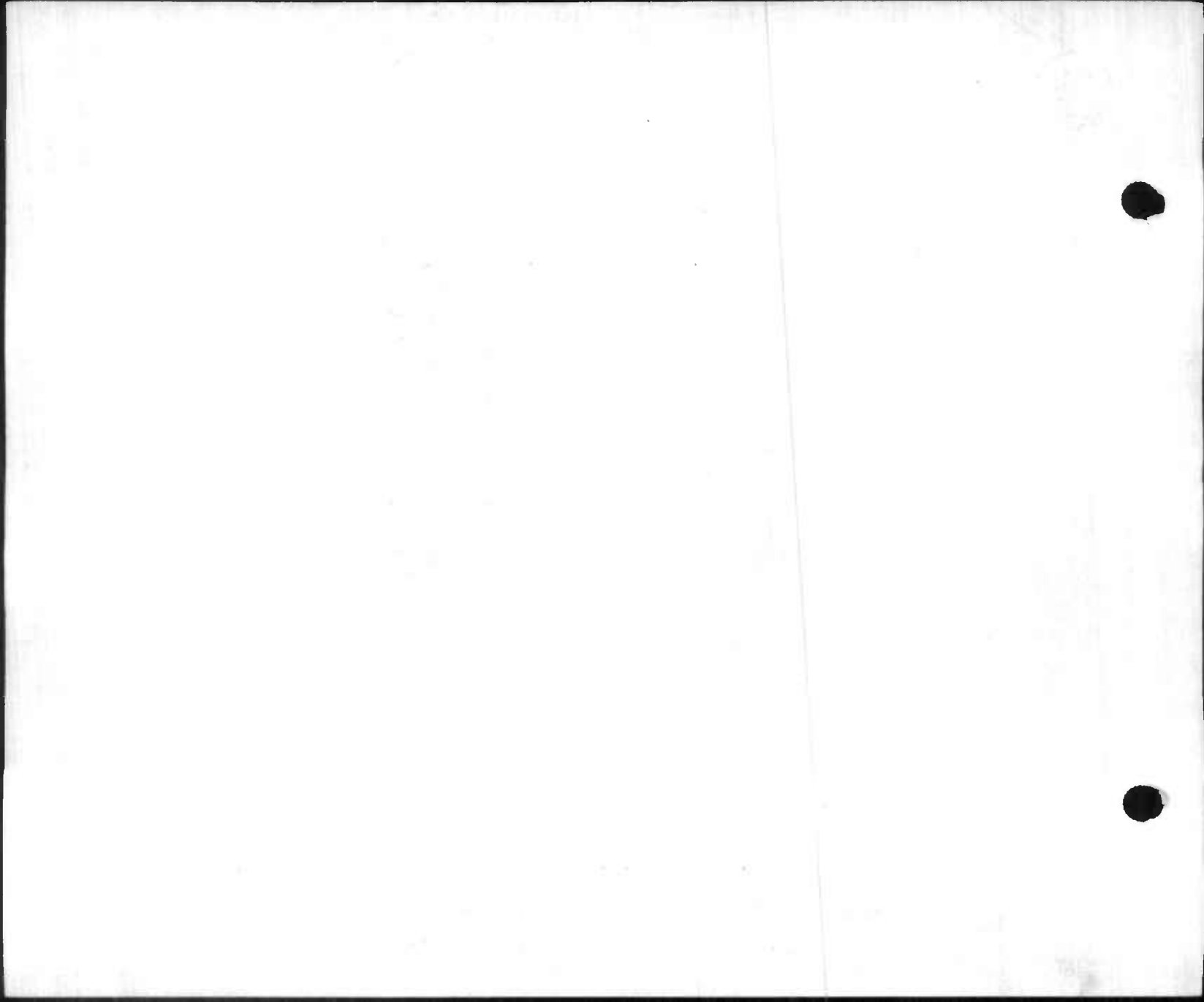


2 0 3 9 1 5

| | | | | |
|--|--|-------------------------------|--|--|
| 74. FUNERAL DIRECTOR
NAME
Wm. C. March F/H | | ADDRESS
1101 E. North Ave. | 75a. DATE REC'D. BY REGISTRAR
FEB 11 1982 | 75b. REGISTRAR'S SIGNATURE
<i>[Signature]</i> |
|--|--|-------------------------------|--|--|

BP _____
DHMH-17
VR A15 ME (5)
15M2/80

1901.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 should be retained by the hospital or attending physician.

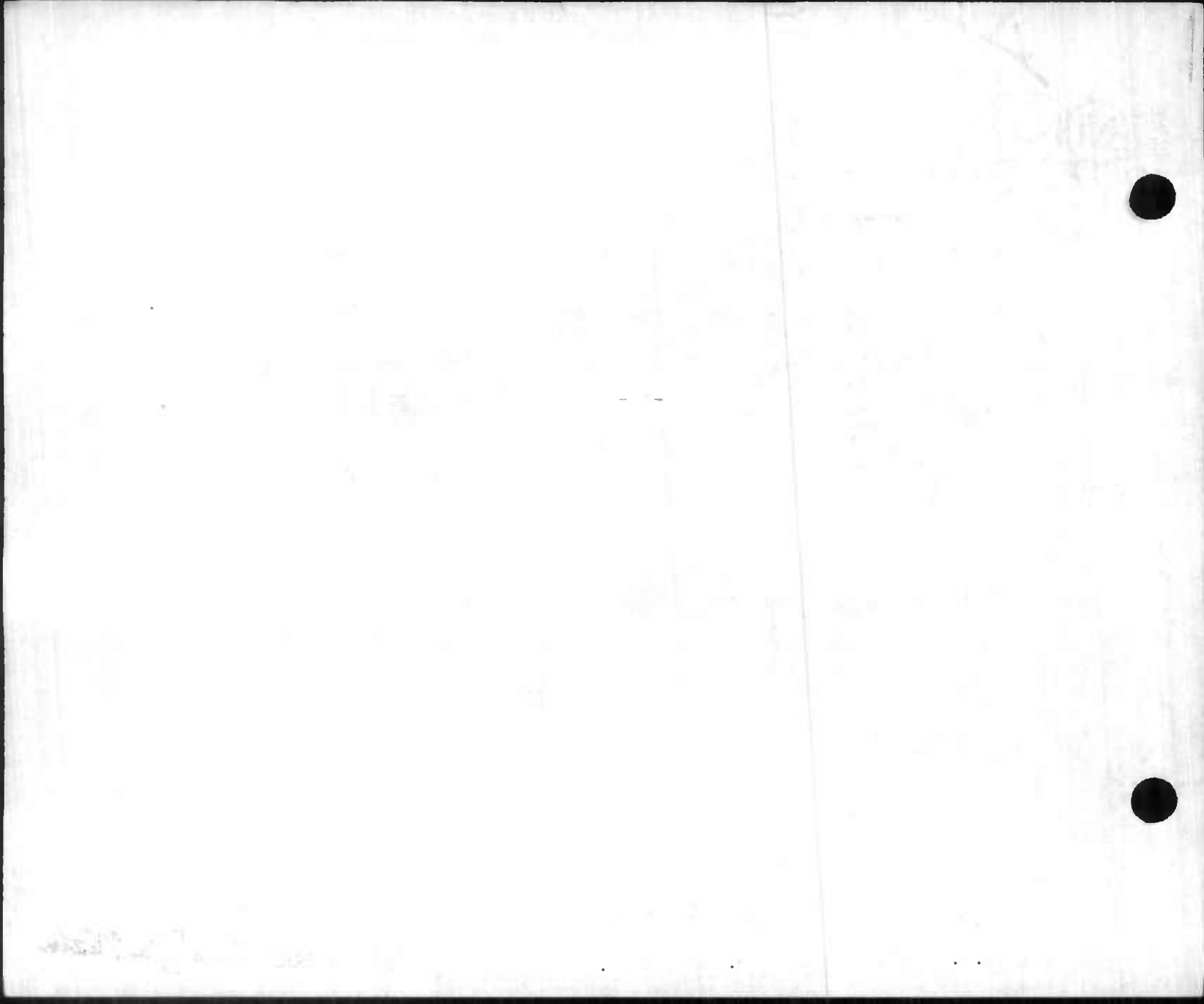
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 18 is marked or item 18 shows any injury, or other traumatic event, the medical examiner will be notified by date.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | |
|---|---|---|---|---|--|
| 1. DECEASED NAME
(TYPE OR PRINT)
FIRST MIDDLE LAST
WILLIAM KITT | | 2a. DATE OF DEATH
MONTH DAY YEAR
02 06 82 | | 2b. HOUR
7:16A M | |
| 3. SEX
M | 4. RACE
B | 5. DATE OF BIRTH
MONTH DAY YEAR
02 12 14 | | 6. AGE (IN YEARS LAST BIRTHDAY)
66Y
IF UNDER 1 YEAR
MONTHS DAYS
IF UNDER 24 HRS
HOURS MIN. | |
| 7a. BIRTHPLACE
(STATE OR FOREIGN COUNTRY)
SOUTH CAROLINA | 7b. CITIZEN OF WHAT COUNTRY?
US | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
CITY MD. | |
| 10. CITY OR TOWN OF DEATH
BALTIMORE | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
SINAI HOSPITAL | | 12a. USUAL OCCUPATION
(TYPE OF WORK OR LINE OF WORKING LIFE)
RETIRED | | 12b. KIND OF BUSINESS OR INDUSTRY |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)
MARYLAND | | 13b. COUNTY
BALTIMORE | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | 13e. STREET ADDRESS
4974 EDGEMERE AVE. | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
WILLIAM KITT | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
ELIZABETH HUNT | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)
YES | | 16b. SOCIAL SECURITY NO.
250-00-0585 | | 17. INFORMANT
ADDRESS
William Kitt 5035 CHALGROVE AVE. | |
| 18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c).
PART 1. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>CARDIO PULMONARY ARREST</u>
4151
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last:
(b) <u>Probably Massive Pulmonary Embolism</u>
(c) <u>History of Pulmonary Emboli</u> | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:
<u>COLD, Asthmatic Bronchitis.</u> | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK AT WORK | | 21e. PLACE OF INJURY
(AT HOME STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>02/06</u> , 19 <u>82</u> , to <u>02/06</u> , 19 <u>82</u> , that (I) (we) last saw the deceased alive on <u>02/06</u> , 19 <u>82</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | |
| 22b. SIGNATURE
Gur Chohan Adhe | | DEGREE
MD | | 22c. DATE SIGNED
02/06/82 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
GUR CAOHAR | | 22e. ADDRESS
Sinai Hospital of Baltimore Md. 21215 | | | |
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)
REMOVAL | | 23b. DATE
2/11/82 | 23c. NAME OF CEMETERY OR CREMATORY
CROWNSVILLE VET | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
SOUTH CAROLINA |
| 24. FUNERAL DIRECTOR
NAME
E.L. PHILLIPS | | ADDRESS
1721 N. MONROE ST. | | 25a. DATE REC'D. BY REGISTRAR
FEB 10 1982 | |
| | | | | 25b. REGISTRAR
James Van Nuthan | |

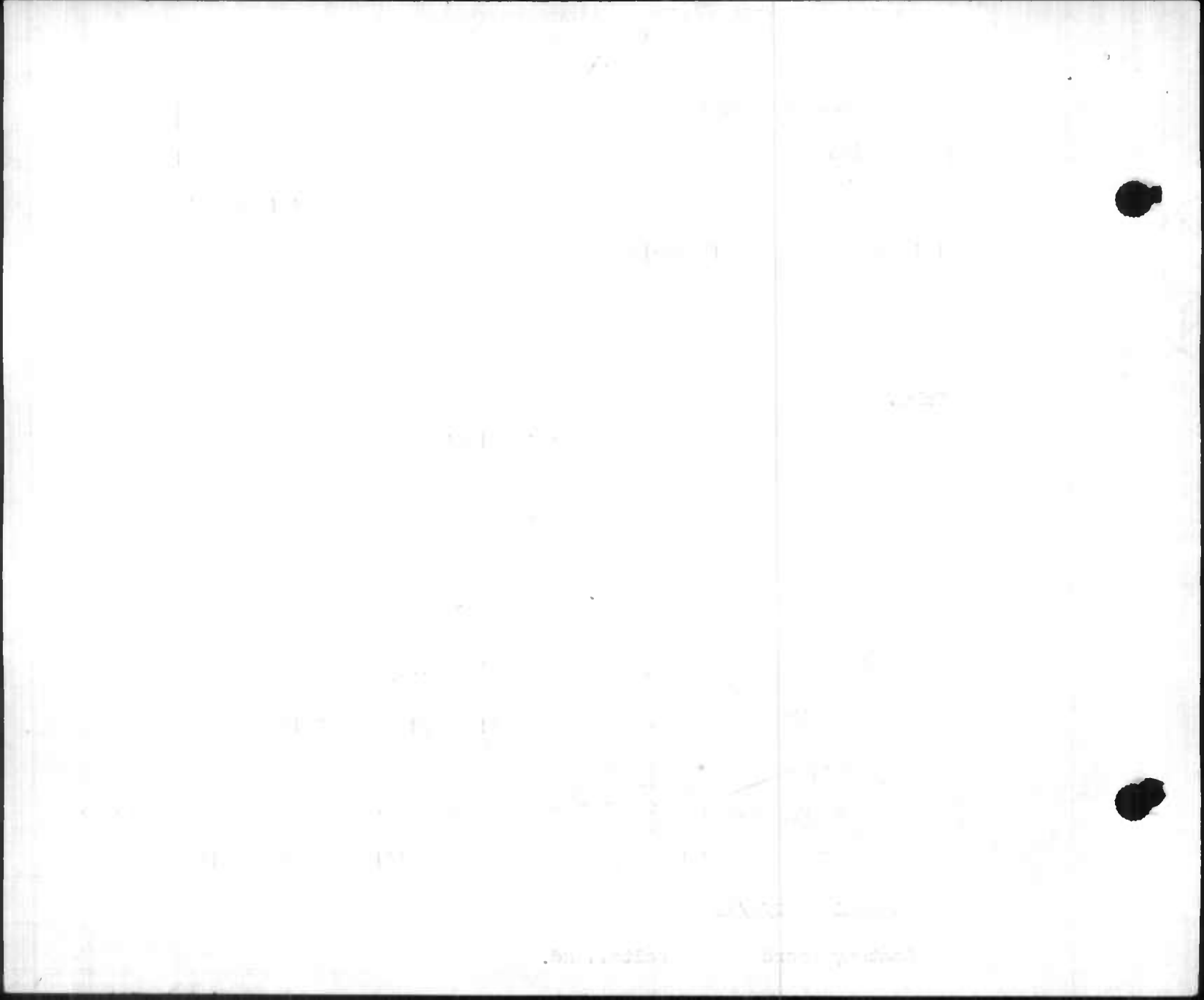


TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

DHMH - 17
(VR A15 ME (5))
15M 2/80

| STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH | | | | | | | | | | REG. NO. 7203917 | | | | | | | | | | | |
|--|--|------------------|--|---|--|--|--|--|--|---|--|--|--|-------------------|--|---|--|---------------------|--|-----------------------|--|
| 1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST
Unknown 82-6 | | | | | | | | | | 2a. DATE KNOWN OF DEATH MONTH DAY YEAR
1 30 1982 | | 2b. HOUR
6 A M | | | | | | | | | |
| 3. SEX
Male | | 4. RACE
White | | 5. DATE OF BIRTH MONTH DAY YEAR
1 30 1982 | | 6. AGE (IN YEARS) (LAST BIRTHDAY) YRS. MONTHS DAYS
4 YRS. | | IF UNDER 1 YR. MONTHS DAYS
IF UNDER 24 HRS. HOURS MIN | | 2c. DATE PRONOUNCED DEAD MONTH DAY YEAR
1 30 1982 | | 2d. HOUR
6 A M | | | | | | | | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) | | | | 7b. CITIZEN OF WHAT COUNTRY? | | | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
Baltimore City, MD. | | | | | | | | | | | |
| 10. CITY OR TOWN OF DEATH
Baltimore | | | | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
44 Albemarle | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | | | | 12b. KIND OF BUSINESS OR INDUSTRY | | | | | | | | | |
| USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) | | | | | | | | | | 13a. STATE | | 13b. COUNTY | | 13c. CITY OR TOWN | | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS | | | |
| 14. FATHER'S NAME FIRST MIDDLE LAST | | | | | | | | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST | | | | | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) Unkn. | | | | | | | | | | 16b. SOCIAL SECURITY NO. | | | | | | | | | | 17. INFORMANT ADDRESS | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Smoke and soot inhalation
8902
Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause lost.
(b)
(c) | | | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | | | | | | | | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a). | | | | | | | | | | | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | | | | | | | | 20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | | | | | | | |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH | | | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR
4:55 PM 1 30 1982 | | | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)
house fire | | | | | | | | | | | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK | | | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)
house | | | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE
44 Albemarle Balto. MD. | | | | | | | | | | | | | |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> | | | | | | | | | | | | | | | | | | | | | |
| ACTUAL SIGNATURE
<i>Thomas D. Smith</i> | | | | TITLE (SPECIFY)
M.D. Deputy Chief | | | | MEDICAL EXAMINER | | | | DATE SIGNED
1/30/82 | | | | | | | | | |
| EXAMINER'S NAME (TYPE OR PRINT)
Thomas D. Smith, M.D. | | | | ADDRESS
111 Penn St. Balto., MD. | | | | | | | | | | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)
Removal | | | | 23b. DATE
2/8/82 | | 23c. NAME OF CEMETERY OR CREMATORY | | | | 23d. LOCATION CITY OR TOWN COUNTY STATE | | | | | | | | | | | |
| 24. FUNERAL DIRECTOR NAME
Anatomy Board | | | | | | ADDRESS
Balto., Md. | | | | 25a. DATE REC'D. BY REGISTRAR
FEB 4 3 1982 | | 25b. REGISTRAR'S SIGNATURE
<i>James J. [Signature]</i> | | | | | | | | | |

BP



STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

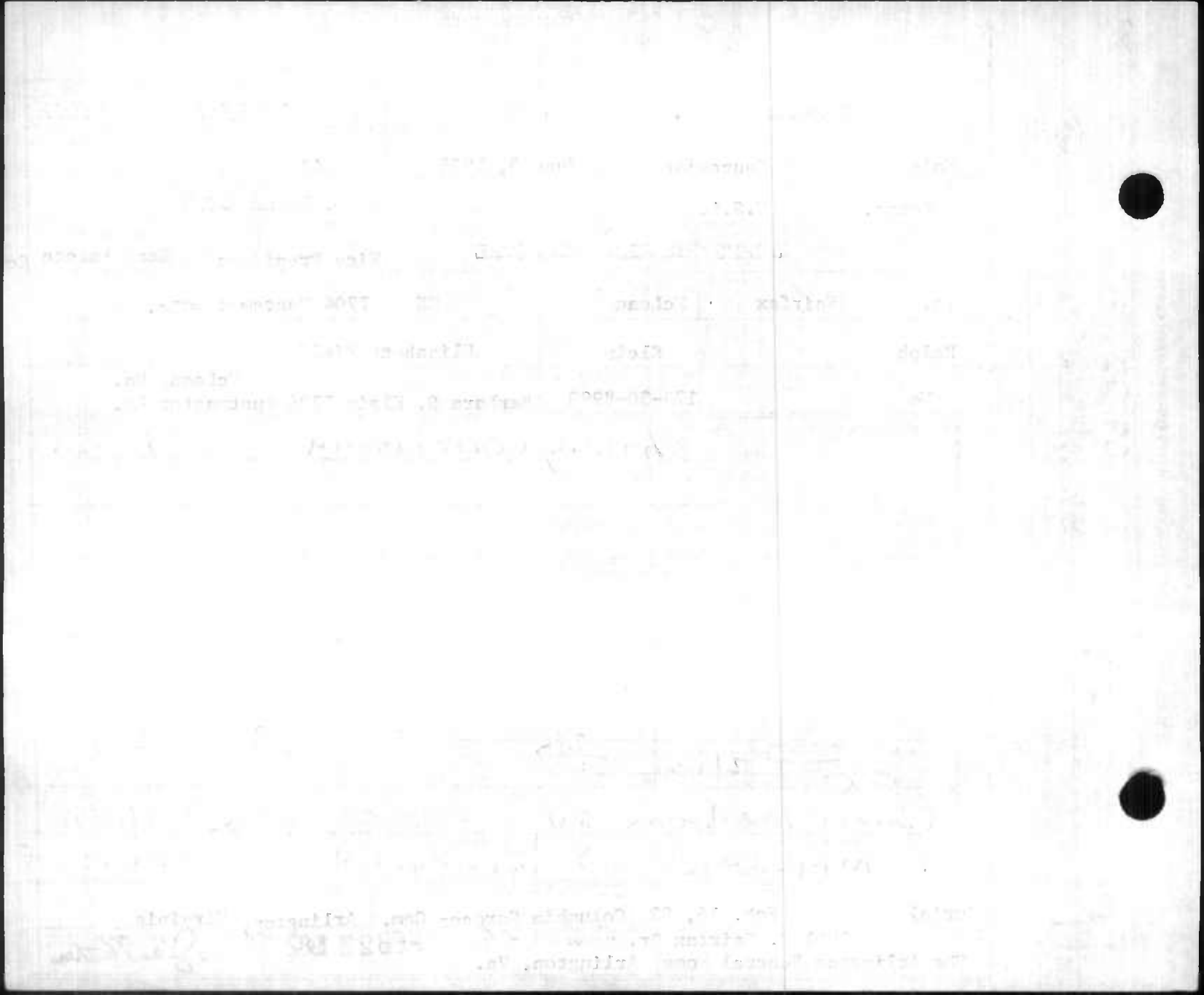
8 2 0 3 9 1 8

| | | | | | |
|--|---|--|---|--|---|
| 1. FOR STATE REGISTRAR | | 2a. DATE OF DEATH | | 2b. HOUR | |
| I. DECEASED NAME (TYPE OR PRINT) | | 2a. DATE OF DEATH | | 2b. HOUR | |
| FIRST MIDDLE LAST | | MONTH DAY YEAR | | HOURS MIN. | |
| RODGER W. KLEIN | | 02/13/82 | | 6:00A _M | |
| 3. SEX | 4. RACE | 5. DATE OF BIRTH | 6. AGE (IN YEARS LAST BIRTHDAY) | IF UNDER 1 YEAR | |
| Male | Caucasian | MONTH DAY YEAR | 43 YRS. | MONTHS DAYS HOURS MIN. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) | 7b. CITIZEN OF WHAT COUNTRY? | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 9. BALTIMORE CITY OR COUNTY OF DEATH | | |
| Penna. | U.S.A. | | BALTIMORE CITY MD | | |
| 10. CITY OR TOWN OF DEATH | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | | 12b. KIND OF BUSINESS OR INDUSTRY |
| | JOHNS HOPKINS HOSPITAL | | Vice President | | Real Estate Co |
| 13a. STATE | | 13b. COUNTY | 13c. CITY OR TOWN | 13d. INSIDE CITY LIMITS? | 13e. STREET ADDRESS |
| Va. | Fairfax | McLean | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | 7704 Huntmaster La. | |
| 14. FATHER'S NAME | | 15. MOTHER'S MAIDEN NAME | | | |
| FIRST MIDDLE LAST | | FIRST MIDDLE LAST | | | |
| Ralph Klein | | Elizabeth Field | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) | | 16b. SOCIAL SECURITY NO. | 17. INFORMANT ADDRESS | | |
| No | | 173-30-8990 | McLean, Va.
Barbara S. Klein 7704 Huntmaster La. | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART 1. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>Cholangiocarcinoma</u>
<u>1551</u>
DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b) _____
DUE TO, OR AS A CONSEQUENCE OF
(c) _____ | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
<u>2 years</u> |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? |
| | | | | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | |
| | | P.M. 19 | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT HOME <input type="checkbox"/> AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | |
| | | | | | |
| 22a. I certify that (I) [this hospital] attended the deceased from <u>2/5</u> 19 <u>82</u> to <u>2/13</u> 19 <u>82</u> , that (I) (we) last saw the deceased alive on <u>2/13</u> 19 <u>82</u> , and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did not) view the body after death. | | | | | |
| 22b. SIGNATURE | | DEGREE | | 22c. DATE SIGNED | |
| Eduardo Marban MD | | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> | | 2/13/82 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) | | 22e. ADDRESS | | | |
| E. MARBAN MD | | Johns Hopkins Hospital Baltimore MD 21205 | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) | | 23b. DATE | 23c. NAME OF CEMETERY OR CREMATORY | | 23d. LOCATION CITY OR TOWN COUNTY STATE |
| Burial | | Feb. 16, 82 | Columbia Gardens Cem. | | Arlington Virginia |
| 24. FUNERAL DIRECTOR | | 25. DATE OF DEATH | | 26. REGISTRAR'S SIGNATURE | |
| 3901 N. Fairfax Dr. Richard D. Fitzgerald | | FEB 23 1982 | | Frances Jan. Nathan | |
| NAME ADDRESS | | ADDRESS | | | |
| The Arlington Funeral Home Arlington, Va. | | | | | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be completed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician, it must be completely filled in by the funeral director. It should be detached for use as the burial-transit permit. Then please detach this certificate and return it to the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.



TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1. FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 2 0 3 9 1 9

REG. NO.

| | | | | | |
|--|--|---|--|--|--|
| 1. DECEASED NAME
(TYPE OR PRINT)
FIRST MIDDLE LAST
JOHN CHARLES KNELL | | | 2a. DATE OF DEATH
MONTH DAY YEAR
2/3/82 | | 2b. HOUR P
1:25 M |
| 3. SEX
Male | 4. RACE
White | 5. DATE OF BIRTH
MONTH DAY YEAR
9 - 6 - 1902 | | 6. AGE (IN YEARS LAST BIRTHDAY)
79 | IF UNDER 1 YEAR
MONTHS DAYS
IF UNDER 24 HRS.
HOURS MIN. |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
Maryland | 7b. CITIZEN OF WHAT COUNTRY?
U.S.A | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 9. BALTIMORE CITY OR COUNTY OF DEATH
Baltimore City MD | | |
| 10. CITY OR TOWN OF DEATH
Baltimore | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
Belair Convalesarium | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
Electrician | | 12b. KIND OF BUSINESS OR INDUSTRY
Beth. Steel Ship Yard |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)
13a. STATE
Maryland | | | 13b. COUNTY
— | 13c. CITY OR TOWN
Baltimore | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
Charles S Knell | | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
Katherine G Kreyborg | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
NO | 16b. SOCIAL SECURITY NO.
(IF YES, GIVE WAR OR DATES)
214-01-9687A | 17. INFORMANT
ADDRESS
Mrs. Mary E. Knell 7514 Harford Rd | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART 1. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) CARDIAC ARREST
1850
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last }
(b) METASTATIC CARCINOMA OF
(c) PROSTATE | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input type="checkbox"/> | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
3/23/82 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | |
| 21d. INJURY OCCURRED
WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | |
| 22a. I certify that (I) (this hospital) attended the deceased from 3/23/82 , 19 78 , to 2/3/82 , 19 82 that (I) (we) lost saw the deceased alive on 2/3/82 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (and staff) were the body after death. | | | | | |
| 22b. SIGNATURE
[Signature] | | DEGREE
ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input checked="" type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | | 22c. DATE SIGNED
2/4/82 |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
Luis E. Rivera, M.D. | | 22e. ADDRESS
50 Scott Adam Road
Cockeysville, Maryland 21030 | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)
Burial | 23b. DATE
2-6-82 | 23c. NAME OF CEMETERY OR CREMATORY
Parkwood Cemetery | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
Baltimore County Md | |
| 24. FUNERAL DIRECTOR
NAME
Hartley Miller Funeral Home | | ADDRESS
7527 Harford Rd. | | 25a. DATE REC'D. BY REGISTRAR
FEB 5 1982 | 25b. REGISTRAR'S SIGNATURE
[Signature] |



Mr.

Mr. [illegible]

[illegible]

[illegible]

[illegible]

Mr.

Mr. [illegible]

[illegible]

[illegible]

[illegible]

[illegible]

Mr. [illegible]

[illegible]

[illegible]

[illegible]

[illegible]

[illegible]

[illegible]

[illegible]



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. The law requires that the death certificate be executed within 24 hours after death. The law requires that the death certificate be executed within 24 hours after death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP

DHMH - 16 50M 1/81
(VRA 15, 4)

| STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH | | | | | | | | | | 8 2 0 3 9 2 0 | | | |
|---|--|--|--|--|--|---|--|---------------------|--|------------------|-----|------------|----------|
| 1. FOR STATE REGISTRAR | | REG. NO. | | | | | | | | | | | |
| 1. DECEASED NAME (TYPE OR PRINT) | | FIRST | | MIDDLE | | LAST | | 2a. DATE OF DEATH | | MONTH | DAY | YEAR | 2b. HOUR |
| CHARLES Henry | | KNIGHT | | | | | | Feb. 28, 1982 | | | | | 11:30 AM |
| 3. SEX | | 4. RACE | | 5. DATE OF BIRTH | | 6. AGE (IN YEARS LAST BIRTHDAY) | | IF UNDER 1 YEAR | | IF UNDER 24 HRS. | | | |
| Male | | White | | Oct. 6, 1908 | | 73 | | MONTHS | | DAYS | | HOURS MIN. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) | | 7b. CITIZEN OF WHAT COUNTRY? | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH | | | | | | | |
| Virginia | | U.S.A. | | | | Baltimore City | | | | | | MD. | |
| 10. CITY OR TOWN OF DEATH | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | | 12b. KIND OF BUSINESS OR INDUSTRY | | | | | | | |
| Baltimore | | Mercy Hospital | | Carman Retired | | Railroad | | | | | | | |
| 13a. STATE | | 13b. COUNTY | | 13c. CITY OR TOWN | | 13d. INSIDE CITY LIMITS? | | 13e. STREET ADDRESS | | | | | |
| Maryland | | Washington | | Hagerstown | | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | RFD-2 | | | | | |
| 14. FATHER'S NAME | | 15. MOTHER'S MAIDEN NAME | | | | | | | | | | | |
| John E. Knight | | Margaret Knight Smith | | | | | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) | | 16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) | | 17. INFORMANT | | ADDRESS | | | | | | | |
| No | | 705-10-4757 | | Mrs. Virginia Knight | | RFD-2 Hag. | | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiorespiratory Failure, day</u> 1639 DUE TO, OR AS A CONSEQUENCE OF (b) <u>CARCINOMA LUNG</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u></u> | | | | | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <u></u> | | | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? | | | | | | | |
| | | | | YES <input type="checkbox"/> NO <input type="checkbox"/> | | YES <input type="checkbox"/> NO <input type="checkbox"/> | | | | | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | | | | | | | |
| | | HOUR A.M. MONTH DAY YEAR | | | | | | | | | | | |
| | | P.M. 19 | | | | | | | | | | | |
| 21d. INJURY OCCURRED | | 21e. PLACE OF INJURY | | 21f. LOCATION | | | | | | | | | |
| WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | STREET | | CITY OR TOWN | | COUNTY | | STATE | | | |
| | | | | | | | | | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>1/29/82</u> , 19 <u>82</u> , to <u>2/28</u> , 19 <u>82</u> , that (I) (we) saw the deceased alive on <u>2/27/82</u> , 19 <u>82</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did not) view the body after death. | | | | | | | | | | | | | |
| 22b. SIGNATURE | | DEGREE | | 22c. DATE SIGNED | | | | | | | | | |
| John R. Davis, MD | | | | 2/28/82 | | | | | | | | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) | | 22e. ADDRESS | | | | | | | | | | | |
| John R. Davis, MD | | 401 MEDICAL ARTS BALTO MD 21201 | | | | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) | | 23b. DATE | | 23c. NAME OF CEMETERY OR CREMATORY | | 23d. LOCATION | | | | | | | |
| Burial | | March 4, 82 | | St. Peters | | Hancock Wash. Md. | | | | | | | |
| 24. REMARKS (FOR FUNERAL HOME USE) | | 25a. DATE REC'D. BY REGISTRAR | | 25b. REGISTRAR'S SIGNATURE | | | | | | | | | |
| FURNERAL HOME | | MAR 8 1982 | | Name Janitor | | | | | | | | | |

MEDICAL CERTIFICATION



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

DHMH-16 50M 1/81
(VRA 15, 4)FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 2 0 3 9 2 1

REG. NO.

| | | | | | |
|--|---|---|---|---|--|
| 1. DECEASED NAME
(TYPE OR PRINT)
FIRST MIDDLE LAST
WILLIAM F KOCHN LEIN | | | 2a. DATE OF DEATH
MONTH DAY YEAR
Feb 18 1982 | | 2b. HOUR
8:30
A M |
| 3 SEX
Male | 4. RACE
White | 5. DATE OF BIRTH
MONTH DAY YEAR
JAN 22 1899 | | 6. AGE (IN YEARS (LAST BIRTHDAY))
85
YRS. | IF UNDER 1 YEAR
MONTHS DAYS
IF UNDER 24 HRS.
HOURS MIN. |
| 7a. BIRTHPLACE
(STATE OR FOREIGN COUNTRY)
BALTO. Md | 7b. CITIZEN OF WHAT COUNTRY?
U.S.A. | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 9. BALTIMORE CITY OR COUNTY OF DEATH
BALTO. City MD. | | |
| 10. CITY OR TOWN OF DEATH
BALTO. City | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
5505 FAIROAK AVE | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
Sewing Mach. Mch. | | 12b. KIND OF BUSINESS OR INDUSTRY
Clothing |
| 13a. STATE
Md | | 13b. COUNTY | 13c. CITY OR TOWN
BALTO | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | 13e. STREET ADDRESS
5505 FAIROAK AVE |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
Charles Koehn LEIN | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
Marie Gerhold | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
No | | 16b. SOCIAL SECURITY NO.
(IF YES, GIVE WAR OR DATES)
212-10-5103 | 17. INFORMANT
ADDRESS
Family Records | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART 1. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>AS CVD - C.H.F.</u>
<u>7140</u>
DUE TO, OR AS A CONSEQUENCE OF
(b) <u>Chenalized arthritis</u>
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last
(c) <u>Ch Renal failure</u> | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a
<u>Heart Hemorrhage</u> | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | |
| 21d. INJURY OCCURRED
WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>Feb 6 1978</u> to <u>Feb 18 1982</u> , that (I) (we) lost saw the deceased alive on <u>Feb 6 1978</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | |
| 22b. SIGNATURE
<u>Donald W. Mintzer</u> | | DEGREE
MD. | | 22c. DATE SIGNED
2/19/82 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
DONALD W. MINTZER M.D. | | 22e. ADDRESS
3009 EVERGREEN AVE | | | |
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)
Burial | 23b. DATE
2/20/82 | 23c. NAME OF CEMETERY OR CREMATORY
Western Cemetery | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
BALTO MD | |
| 24. FUNERAL DIRECTOR
NAME
EVANS Funeral Chapel | | ADDRESS
8800 HARTFORD RD | | 25a. DATE REC'D. BY REGISTRAR
FEB 22 1982 | 25b. REGISTRAR'S SIGNATURE
<u>James J. [Signature]</u> |

MEDICAL CERTIFICATION

2
9

1

2706 BP



TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 3 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE RETURNED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

DHMH - 17
(VR A15 ME (5))
15M 2/80

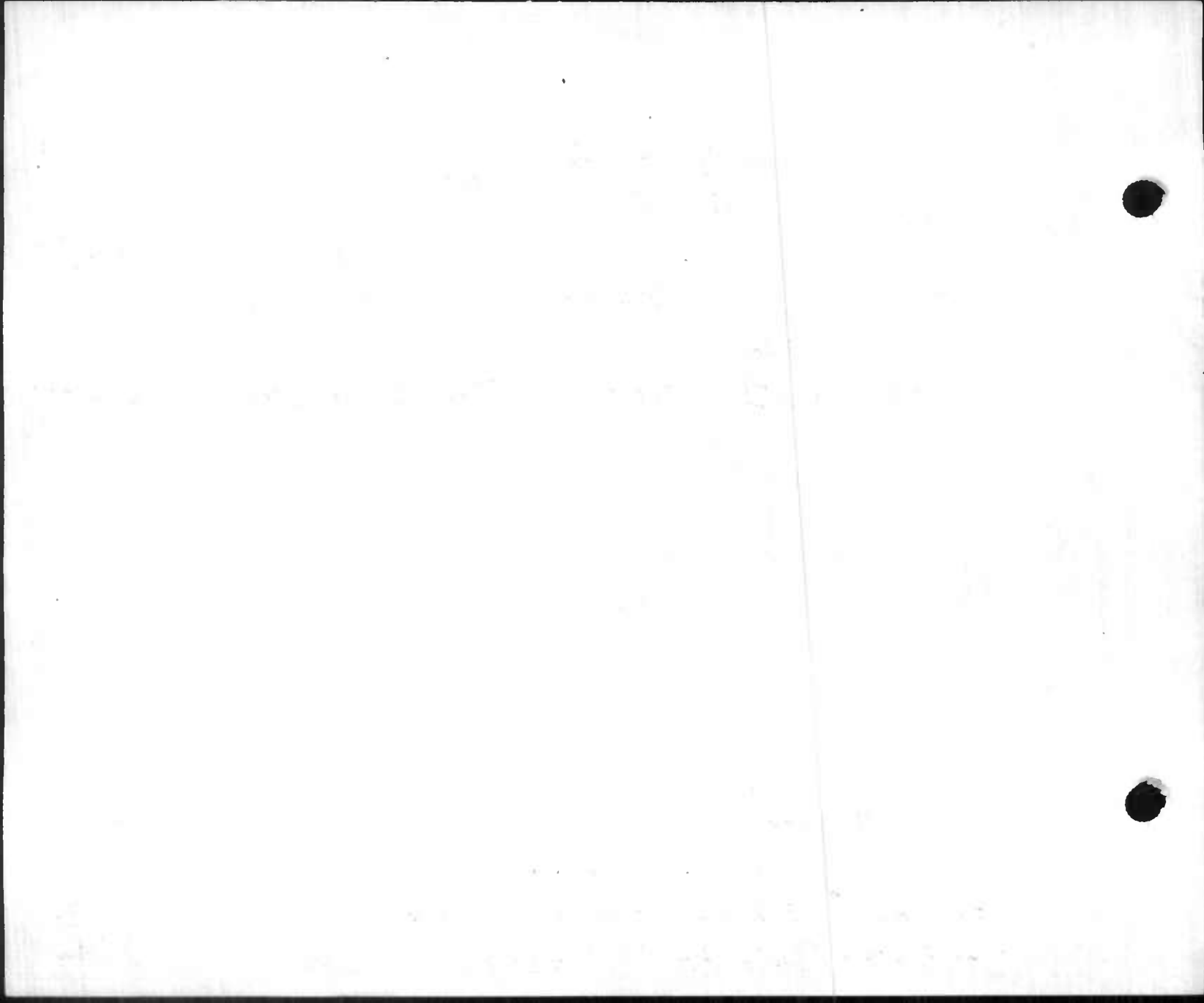
STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

FOR
1- STATE
REGISTRAR

| | | | | | | | | | | | | | | | | | |
|--|--|-------------|--|---|--|------------------------------------|--|---|---|---------------------------|--|--------------------------------------|-----------------------|----------|--|------------|--|
| 1. DECEASED NAME
(TYPE OR PRINT) | | | FIRST MIDDLE LAST | | | 2a. DATE KNOWN OF DEATH | | | | MONTH DAY YEAR | | | | 2b. HOUR | | | |
| Robert C. Koelker | | | | | | XX | | | | 2 25 1982 | | | | M | | | |
| 3. SEX | | 4. RACE | | 5. DATE OF BIRTH | | 6. AGE (IN YEARS) | | IF UNDER 1 YR. | | IF UNDER 24 HRS. | | 2c. DATE PRONOUNCED DEAD | | | | 2d. HOUR | |
| Male | | White | | FEB. 19, 1910 | | 72 YRS. | | MONTHS DAYS | | HOURS MIN. | | 2 25 1982 | | | | 9:05 P. M. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) | | | 7b. CITIZEN OF WHAT COUNTRY? | | | 8. MARRIED | | | NEVER MARRIED | | | 9. BALTIMORE CITY OR COUNTY OF DEATH | | | | | |
| MD. | | | U.S.A. | | | WIDOWED | | | DIVORCED | | | Baltimore City, MD. | | | | | |
| 10. CITY OR TOWN OF DEATH | | | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) | | | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | | | | 12b. KIND OF BUSINESS | | | | |
| Baltimore | | | 924 S. Robinson Street | | | | | | RETIRED | | | | NATURAL BREW. | | | | |
| USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) | | | | | | | | | | | | | | | | | |
| 13a. STATE | | 13b. COUNTY | | 13c. CITY OR TOWN | | 13d. INSIDE CITY LIMITS? | | 13e. STREET ADDRESS | | | | | | | | | |
| MD. | | | | BALTO. | | YES NO | | 924 S. ROBINSON ST. | | | | | | | | | |
| 14. FATHER'S NAME | | | | 15. MOTHER'S MAIDEN NAME | | | | | | | | | | | | | |
| FIRST MIDDLE LAST | | | | FIRST MIDDLE LAST | | | | | | | | | | | | | |
| UNKNOWN | | | | UNKNOWN | | | | | | | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO, OR UNKNOWN) | | | | 16b. SOCIAL SECURITY NO. | | | | 17. INFORMANT | | | | ADDRESS | | | | | |
| YES | | | | 214-05-5013 | | | | DORIS E. KOELKER | | | | SAME 21224 | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I DEATH WAS CAUSED BY:
4292 IMMEDIATE CAUSE (a) Arteriosclerotic Cardiovascular Disease
Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.
(b) _____
(c) _____
DUE TO, OR AS A CONSEQUENCE OF
DUE TO, OR AS A CONSEQUENCE OF
DUE TO, OR AS A CONSEQUENCE OF | | | | | | | | | | | | | | | | | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 a. | | | | | | | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | | | | | | | | 20. AUTOPSY? | | | | | |
| | | | | | | | | | | | | YES NO XX | | | | | |
| 21a. EXTERNAL CAUSE WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH | | | | 21b. TIME OF INJURY | | | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) | | | | | | | | | |
| | | | | P.M. 19 | | | | | | | | | | | | | |
| 21d. INJURY OCCURRED WHILE AT WORK NOT WHILE AT WORK | | | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) | | | | 21f. LOCATION | | | | | | | | | |
| | | | | | | | | STREET CITY OR TOWN COUNTY STATE | | | | | | | | | |
| 22a. I certify that I took charge of the remains described above, held an Autopsy Inspection Inquiry and in my opinion death resulted from: Natural causes Accident Suicide Homicide Undetermined manner | | | | | | | | | | | | | | | | | |
| Actual Signature: Margarita A. Korell, M.D. TITLE (SPECIFY) Assistant MEDICAL EXAMINER DATE SIGNED 2-26-82 | | | | | | | | | | | | | | | | | |
| EXAMINER'S NAME (TYPE OR PRINT) Margarita A. Korell, M.D. ADDRESS 111 Penn Street | | | | | | | | | | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (PRECISELY) | | | | 23b. DATE | | 23c. NAME OF CEMETERY OR CREMATORY | | | | 23d. LOCATION | | | | | | | |
| BURIAL | | | | 3-2-82 | | CROWNSVILLE V.A. CEM. | | | | CITY OR TOWN COUNTY STATE | | | | | | | |
| | | | | | | | | | | P.A. Co. MD. | | | | | | | |
| 24. FUNERAL DIRECTOR | | | | | | | | | | | | | | | | | |
| NAME ADDRESS DATE REC'D. BY REGISTRAR REGISTRAR'S SIGNATURE | | | | | | | | | | | | | | | | | |
| Hoffman - Skarda FH 3218 HUDSON MAR 1 1982 Frances Jean Nathan | | | | | | | | | | | | | | | | | |

BP



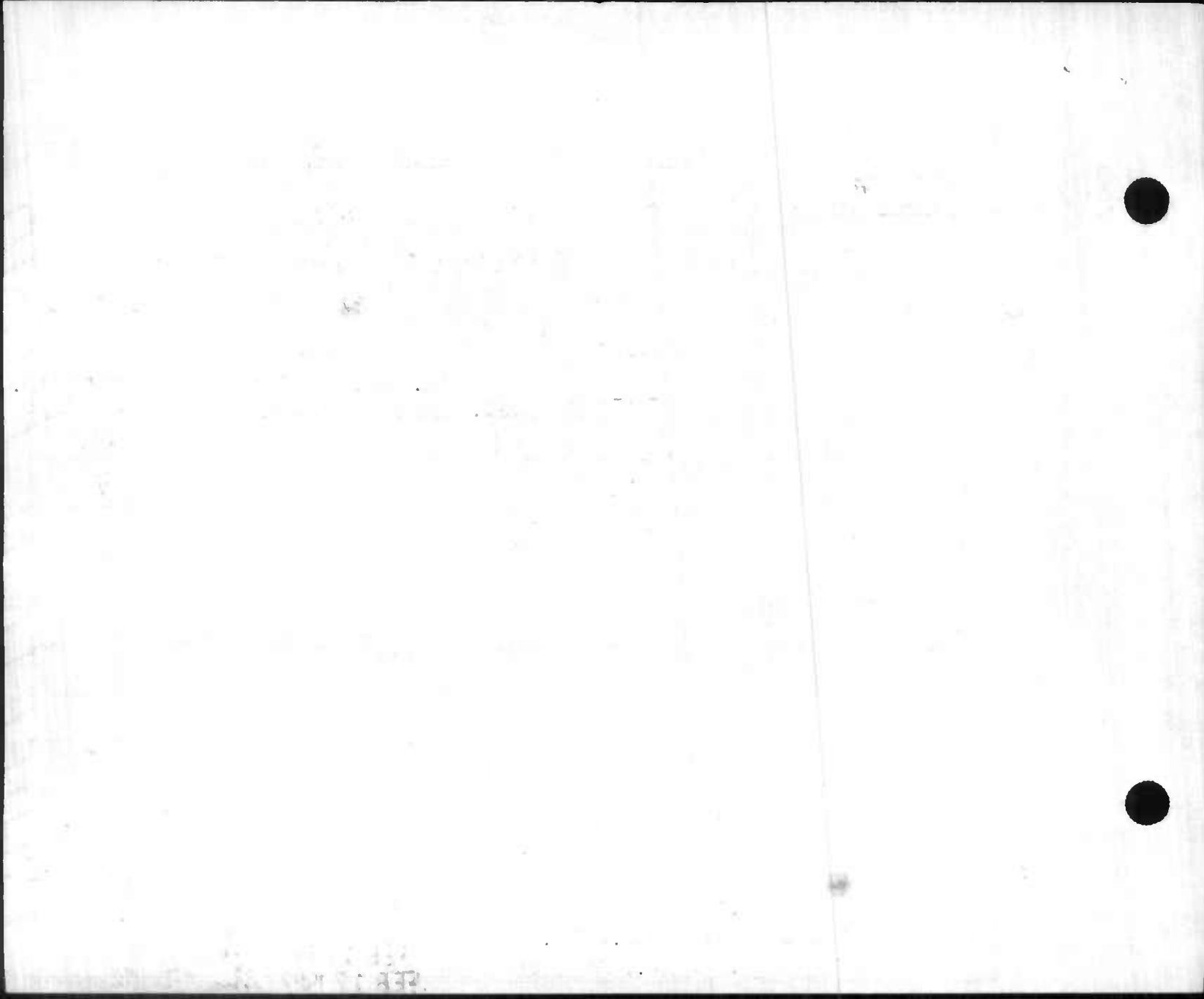
STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 2 0 3 7 2 3

1- FOR
STATE
REGISTRAR

REG. NO.

| | | | | | | | | | |
|---|--|--|--|---|---|--|---|--|--|
| 1. DECEASED NAME
(TYPE OR PRINT) BESSIE KOENIGSBERG | | | 2a. DATE OF DEATH
MONTH DAY YEAR
FEB 13 1982 | | | 2b. HOUR
9⁰⁰ | | | |
| 3. SEX
FEMALE | | 4. RACE
WHITE | | 5. DATE OF BIRTH
MONTH DAY YEAR
3 24 1902 | | 6. AGE (IN YEARS LAST BIRTHDAY)
81 79 | | 7. UNDER 1 YEAR
MONTHS DAYS
81 79 | |
| 7a. BIRTHPLACE
COUNTRY
XXXXXX XXXX | | 7b. CITIZEN OF WHAT COUNTRY?
U.S.A. | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
BALTO CITY MD. | | | |
| 10. CITY OR TOWN OF DEATH
BALTO CITY | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
LEVINSON GERIATRIC HSP | | | | 12a. US HOUSEWARE
(TYPE OF WORK FOR MOST OF WORKING LIFE)
XXXXXX | | 12b. KIND OF BUSINESS OR INDUSTRY
AT HOME | |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) | | | | | | | | | |
| 13a. STATE
MARYLAND | | 13b. COUNTY
BALTIMORE | | 13c. CITY OR TOWN
BALTIMORE | | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
UNKNOWN GOLDBERG | | | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
UNKNOWN | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
NO | | 16b. SOCIAL SECURITY NO.
218-01-2003A | | 17. INFORMANT
ADDRESS
MR. DAVID KOENIGSBERG 2900 GLEN AVE. BALTO., MD 21215 | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
4100 IMMEDIATE CAUSE (a) Acute MI
DUE TO, OR AS A CONSEQUENCE OF
(b) CHF
DUE TO, OR AS A CONSEQUENCE OF
(c) ASVD
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I. | | | | | | | | | |
| 19a. DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
10 11 19 82 | | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | |
| 21d. INJURY OCCURRED
WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | |
| 22a. I certify that (this hospital) attended the deceased from 2-10-82 to 2-13-82 , that (we) lost
saw the deceased alive on 2-13-82 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated
above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | |
| 22b. SIGNATURE
LIST | | | DEGREE | | | ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input checked="" type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | 22c. DATE SIGNED
2-13-82 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
LIST | | | 22e. ADDRESS
Greenspring & Northen Hwy 21215 | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY) BURIAL | | | 23b. DATE
FEB. 15, 1982 | | 23c. NAME OF CEMETERY OR CREMATORY
HAR ZION TIFERETH ISRAEL | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
ROSEDALE BALTO. MD | | |
| 24. FUNERAL DIRECTOR
NAME ADDRESS
SOL LEVINSON & BROS., INC. 6010 REISTERSTOWN RD. BALTO., MD 21215 | | | | | 25a. DATE REC'D. BY REGISTRAR
FEB 17 1982 | | 25b. REGISTRAR'S SIGNATURE
[Signature] | | |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 2 0 3 9 2 4

REG. NO.

1. FOR
STATE
REGISTRAR

| | | | | | | | | | |
|--|--|--|--|---|--|---|--|--|--|
| 1. DECEASED NAME
(TYPE OR PRINT) CHRISTOS G. KOKINOS | | | 2a. DATE OF DEATH
MONTH 2 DAY 4 YEAR 82 | | | 2b. HOUR
555-A | | | |
| 3. SEX
Male | | 4. RACE
White | | 5. DATE OF BIRTH
MONTH 06 DAY 29 YEAR 1912 | | 6. AGE (IN YEARS LAST BIRTHDAY)
69 YRS. | | 7. IF UNDER 1 YEAR
MONTHS DAYS HOURS MIN. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
Greece | | 7b. CITIZEN OF WHAT COUNTRY?
U.S.A. | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
Baltimore City MD. | | | |
| 10. CITY OR TOWN OF DEATH
Baltimore | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
Sinai Hospital | | | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
Retired | | | |
| 12b. KIND OF BUSINESS OR INDUSTRY
Co-Owner of Motels | | | | | | | | | |
| 13a. STATE
Maryland | | 13b. COUNTY
Baltimore | | 13c. CITY OR TOWN
Towson | | 13d. INSIDE CITY LIMITS?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 13e. STREET ADDRESS
1809 Leadburn Road, 21204 | |
| 14. FATHER'S NAME
FIRST George MIDDLE LAST Kokinos | | | | 15. MOTHER'S MAIDEN NAME
FIRST Zacharoula MIDDLE LAST Klicos | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
Yes | | 16b. SOCIAL SECURITY NO.
(IF YES, GIVE YEAR OR DATES)
WWII | | 17. INFORMANT
Mrs. Esther Kokinos, same as #13e | | ADDRESS | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Adenocarcinoma c nodes Probable
1991
DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.
(b) recurrent disease,
DUE TO, OR AS A CONSEQUENCE OF
(c) | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) | | | | | | | | | |
| 19a. DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/> | | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 11/21 19 82 , to 2/4 19 82 , that (I) (we) last saw the deceased alive on 2/4 19 82 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) did (did not) view the body after death. | | | | | | | | | |
| 22b. SIGNATURE
CLAUDIO LEVIN | | | | | | DEGREE
MD | | 22c. DATE SIGNED
2/4/82 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
CLAUDIO LEVIN | | | | | | 22e. ADDRESS
Sinai Hospital | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)
Burial | | | 23b. DATE
2-8-82 | | 23c. NAME OF CEMETERY OR CREMATORY
Greek Orthodox Cemetery | | 23d. LOCATION
CITY OR TOWN Woodlawn, Maryland COUNTY STATE | | |
| 24. FUNERAL DIRECTOR
Ruck Towson Funeral Home, Inc. | | | | | | 25a. DATE REC'D. BY REGISTRAR
FEB 5 1982 | | 25b. REGISTRAR'S SIGNATURE
James J. Smith | |



KOMINSKI, HELEN

MICU 77

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be completed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon copies. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

DHMM-16 30M 2/80
(VRA 15, 4)1 - FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 2 0 3 9 2 5

REG. NO.

| | | | | | | | | | | |
|---|--|---|--|--|--|--|--|--|--|--|
| 1. DECEASED NAME
(TYPE OR PRINT)
FIRST MIDDLE LAST
Helen L Kominski | | | 2a. DATE OF DEATH
MONTH DAY YEAR
2-11-82 | | | 2b. HOUR
MIN.
12:52P | | | | |
| 3. SEX
FEMALE | | 4. RACE
WHITE | | 5. DATE OF BIRTH
MONTH DAY YEAR
12-31-1923 | | 6. AGE (IN YEARS LAST BIRTHDAY)
58 YRS. | | IF UNDER 1 YEAR
MONTHS DAYS
IF UNDER 24 HRS.
HOURS MIN. | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
MARYLAND | | 7b. CITIZEN OF WHAT COUNTRY?
U.S.A. | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
Baltimore City MD. | | | | |
| 10. CITY OR TOWN OF DEATH
BALTO | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
Johns Hopkins Hospital | | | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
LABORER | | 12b. KIND OF BUSINESS OR INDUSTRY
AM CAR | | |
| 13a. STATE
md | | | 13b. COUNTY | | 13c. CITY OR TOWN
BALTO | | 13d. INSIDE CITY LIMITS?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS
519 S. COLLINGTON | |
| 14. FATHER'S NAME
(LAST)
JOHN | | | MIDDLE
BAUBERT | | 15. MOTHER'S MAIDEN NAME
(LAST)
HELEN | | | MIDDLE
COLLINS LAST | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
NO | | | 16b. SOCIAL SECURITY NO.
215-16-7625 | | 17. INFORMANT
RUSSELL STORIE | | | ADDRESS
519 S. COLLINGTON | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>cardiopulmonary arrest</u>
4249
DUE TO, OR AS A CONSEQUENCE OF
(b) <u>cardiac valve disease</u>
DUE TO, OR AS A CONSEQUENCE OF
(c) _____
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
15 minutes
YEARS. | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) | | | | | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK AT WORK | | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>2/10</u> , 19 <u>82</u> , to <u>2/11</u> , 19 <u>82</u> , that (I) (we) lost
saw the deceased alive on <u>2/11</u> , 19 <u>82</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated
above. (I) (we) did not view the body after death. | | | | | | | | | | |
| 22b. SIGNATURE
X P Sholar, MD. | | | | | DEGREE
ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> | | | 22c. DATE SIGNED
2/11/82 | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
PAUL STELLAR | | | | | 22e. ADDRESS
JOHNS HOPKINS HOSP, BALTIMORE | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)
BURIAL | | | 23b. DATE
2-15-82 | | 23c. NAME OF CEMETERY OR CREMATORY
OAKLAND CEM | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
BALTO MD | | | |
| 24. FUNERAL DIRECTOR
NAME
JOHN M. WEBER | | | | | ADDRESS
1502 N. S. CHASE | | 25. DATE REC'D. BY REGISTRAR
2-16-1982 | | | |
| | | | | | 26. REGISTRAR'S SIGNATURE
Theresa J. [Signature] | | | | | |

100-22-200-1-E
11/10/10
11/10/10

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. It may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 2 0 3 9 2 6

| | | | | | |
|---|--|--|---|---|--|
| 1. FOR STATE REGISTRAR | | 2a. DATE OF DEATH | | 2b. HOUR | |
| 1. DECEASED NAME (TYPE OR PRINT) | | 2a. DATE OF DEATH | | 2b. HOUR | |
| FIRST MIDDLE LAST | | MONTH DAY YEAR | | HOURS MIN. | |
| KONICK CELIA KONICK | | 2/8/82 | | 5:08 P.M. | |
| 3. SEX | 4. RACE | 5. DATE OF BIRTH | 6. AGE (IN YEARS LAST BIRTHDAY) | 7. BALTIMORE CITY OR COUNTY OF DEATH | |
| FEMALE | CAUCASIAN | MONTH DAY YEAR | 82 83 YRS. | BALTIMORE CITY MD. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) | 7b. CITIZEN OF WHAT COUNTRY? | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/> | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | | |
| POLAND | USA | | COMPANION | | |
| 10. CITY OR TOWN OF DEATH | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) | 12b. KIND OF BUSINESS OR INDUSTRY | | | |
| BALTIMORE | SINAI HOSPITAL | DOMESTIC | | | |
| 13a. STATE | 13b. COUNTY | 13c. CITY OR TOWN | 13d. INSIDE CITY LIMITS? | 13e. STREET ADDRESS | |
| MARYLAND | | BALTIMORE | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | APT. 1003
2500 W. BELVEDERE AVE. 21215 | |
| 14. FATHER'S NAME | 15. MOTHER'S MAIDEN NAME | 17. INFORMANT | | | |
| FIRST MIDDLE LAST | FIRST MIDDLE LAST | MRS. FLORENCE ROSENBERG | | | |
| UNKNOWN | KUSHNER | 1026 E. 27th ST. BROOKLYN, NY 11210 | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) | 16b. SOCIAL SECURITY NO. | 17. INFORMANT | | | |
| NO | | MRS. FLORENCE ROSENBERG | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Cardio Pulmonary Arrest.</u> | | | | | |
| 4100 | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF | | | | | |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. | | | | | |
| (b) <u>Acute Myocardial Infarction.</u> | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF | | | | | |
| (c) <u>And Cardiogenic shock.</u> | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) | | | | | |
| 19a. DATE OF OPERATION | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | 20a. AUTOPSY? | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? | | |
| | | YES <input type="checkbox"/> NO <input type="checkbox"/> | YES <input type="checkbox"/> NO <input type="checkbox"/> | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | |
| | P.M. 19 | | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) lost saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | |
| 22b. SIGNATURE | DEGREE | ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | 22c. DATE SIGNED | | |
| D. S. PATEL | MD | | 2.8.82. | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) | 22e. ADDRESS | | | | |
| D. S. PATEL | SINAI HOSPITAL | | | | |
| 23a. BURIAL, CREMATION, REMOVAL | 23b. DATE | 23c. NAME OF CEMETERY OR CREMATORY | 23d. LOCATION | | |
| REMOVAL/BURIAL | FEB. 9, 1982 | NEW MONTEFIORE | PINELAWN E.T. NY STATE | | |
| 24. FUNERAL DIRECTOR | | 25a. DATE REC'D. BY REGISTRAR | | 25b. REGISTRAR'S SIGNATURE | |
| SOL LEVINSON & BROS., INC. | | FEB 11 1982 | | James J. Van Natten | |
| 6010 REISTERSTOWN RD. BALTO., MD 21215 | | | | | |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

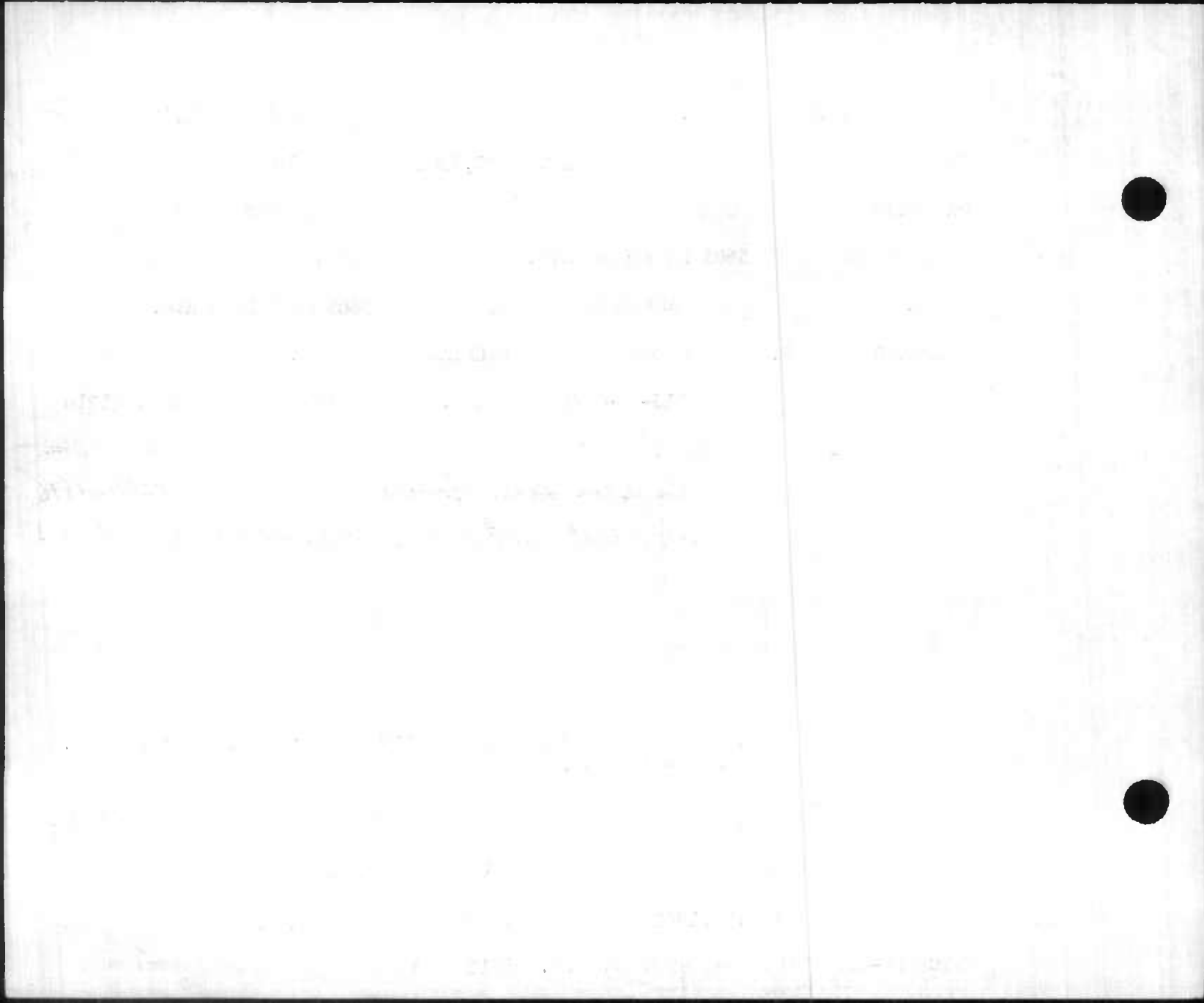
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical certificate must be completed in case.DHMH-16 50M 1/81
(VRA 15, 4)STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 2 0 3 9 2 7

REG. NO.

| | | | | | |
|---|--|--|---|--|-----------------------------------|
| 1 - FOR STATE REGISTRAR | | 2a. DATE OF DEATH | | 2b. HOUR | |
| 1 DECEASED NAME (TYPE OR PRINT) | | 2a. DATE OF DEATH | | 2b. HOUR | |
| EDGAR E. KONOW | | FEBRUARY 22, 1982 | | 10 ⁰⁰ - M | |
| 3 SEX | 4 RACE | 5. DATE OF BIRTH | 6. AGE (IN YEARS LAST BIRTHDAY) | IF UNDER 1 YEAR | |
| MALE | WHITE | AUGUST 27, 1902 | 79 YRS. | IF UNDER 24 HRS. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) | 7b. CITIZEN OF WHAT COUNTRY? | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 9. BALTIMORE CITY OR COUNTY OF DEATH | | |
| MARYLAND | USA | | BALTIMORE CITY MD. | | |
| 10 CITY OR TOWN OF DEATH | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | | 12b. KIND OF BUSINESS OR INDUSTRY |
| BALTIMORE | 5605 LAURELTON AVE. | | TELLER | | BANK |
| 13a. STATE | | 13b. COUNTY | 13c. CITY OR TOWN | 13d. INSIDE CITY LIMITS? | 13e. STREET ADDRESS |
| MD. | | | BALTIMORE | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | 5605 LAURELTON AVE. |
| 14. FATHER'S NAME | | 15. MOTHER'S MAIDEN NAME | | | |
| EDWARD H. KONOW | | LILLIAN L. SCHMIDT | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) | | 16b. SOCIAL SECURITY NO | | 17. INFORMANT ADDRESS | |
| NO | | 215-09-3940 | | ERIKA H. KONOW 5605 LAURELTON AVE. 21214 | |
| 18. CAUSE OF DEATH: Enter only one cause per line for (a), (b), and (c).
PART 1. DEATH WAS CAUSED BY
IMMEDIATE CAUSE (a) <u>Cardiac arrest</u>
4100
DUE TO, OR AS A CONSEQUENCE OF
(b) <u>Engelsten Heart Failure</u>
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO, OR AS A CONSEQUENCE OF
(c) <u>arteriosclerotic heart disease & myocardial infarction</u>
October 1978 | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1. | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? | |
| | | | | YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | |
| 21d. INJURY OCCURRED
WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>February 22</u> 19 <u>82</u> to <u>Feb 22</u> 19 <u>82</u> , that (we) last saw the deceased person <u>above (I) and did not view the body after death.</u> and that in (our) opinion death occurred on the date and hour and from the causes stated | | | | | |
| 22b. SIGNATURE | | DEGREE | | 22c. DATE SIGNED | |
| <u>Edward J. Alessi</u> | | | | <u>2/22/82</u> | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) | | 22e. ADDRESS | | | |
| EDWARD J. ALESSI | | 6217 HARFORD RD. | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) | | 23b. DATE | 23c. NAME OF CEMETERY OR CREMATORY | 23d. LOCATION | |
| BURIAL | | FEB. 25, 1982 | LOUDON PARK CEM. | BALTIMORE MD. | |
| 24. FUNERAL DIRECTOR | | 25a. DATE REC'D. BY REGISTRAR | | 25b. REGISTRAR'S SIGNATURE | |
| NAME ADDRESS | | FEB 26 1982 | | <u>James J. [Signature]</u> | |
| MITCHELL-WIEDEFELD HOME 6500 YORK RD. 21212 | | | | | |

2706 BP

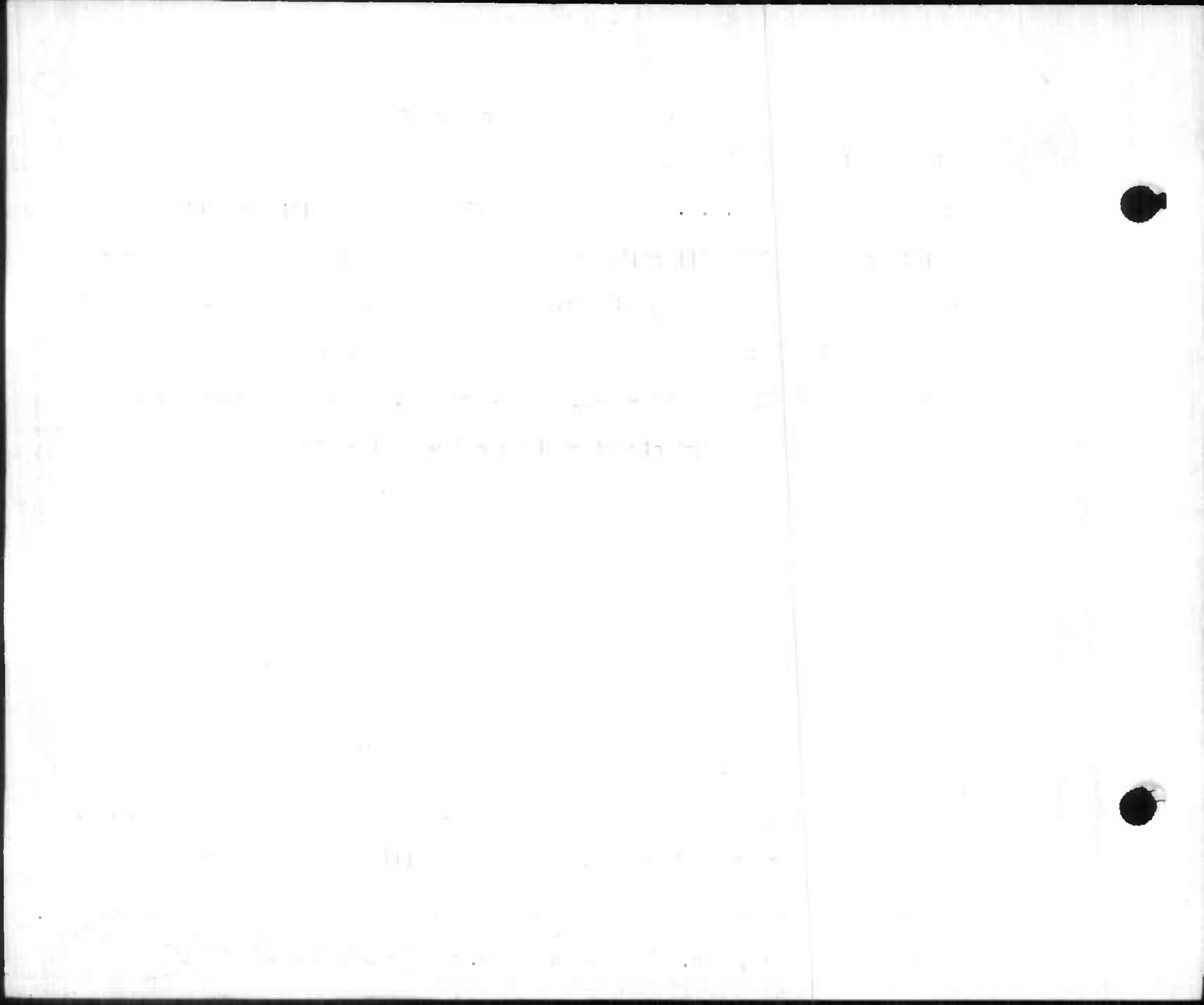


TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR RECORDS. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 24 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

MEDICAL CERTIFICATION

| STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH | | | | | | | | | | REG. NO. 8 2 0 3 9 2 8 | |
|--|--|------------------|-------------|---|--|--|--|---|---|---|--|
| 1. DECEASED NAME
(TYPE OR PRINT) FIRST MIDDLE LAST
Adam John Kornberger | | | | | | 2a. DATE KNOWN OF DEATH
ESTIMATED <input checked="" type="checkbox"/> MONTH DAY YEAR
2 22 1982 | | | 2b. HOUR
M
10:09 a.m. | | |
| 3. SEX
Male | | 4. RACE
White | | 5. DATE OF BIRTH
MONTH DAY YEAR
2 19 10 | | 6. AGE (IN YEARS)
(LAST BIRTHDAY) 72 YRS. | | IF UNDER 1 YR.
MONTHS DAYS | | IF UNDER 24 HRS.
HOURS MIN. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
Maryland | | | | 7b. CITIZEN OF WHAT COUNTRY?
U.S.A. | | | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
Baltimore City, MD | |
| 10. CITY OR TOWN OF DEATH
Baltimore | | | | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
3308 Eilerslie Avenue | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)
Plumber | | 12b. KIND OF BUSINESS OR INDUSTRY
--- | |
| USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) | | | | | | | | | | | |
| 13a. STATE
Maryland | | | 13b. COUNTY | | | 13c. CITY OR TOWN
Baltimore | | | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
UNKNOWN | | | | | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
UNKNOWN | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO, OR UNKNOWN)
YES | | | | 16b. SOCIAL SECURITY NO.
(IF YES, GIVE WAR OR DATES)
WW II 214-05-1847 | | | | 17. INFORMANT
ADDRESS
Joseph C. Klein 810 Dorchester Road 21229 | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>Arteriosclerotic cardiovascular disease</u>
4292
Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last:
(b) _____
(c) _____
DUE TO, OR AS A CONSEQUENCE OF | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | | | | | | 20. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 21a. EXTERNAL CAUSE WAS
UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH | | | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) | | | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/> | | | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) | | | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | |
| 22a. I certify that I took charge of the remains described above, held on death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion | | | | | | | | | | | |
| ACTUAL SIGNATURE <u>Hormez R. Guard</u> | | | | | | TITLE (SPECIFY)
M.D. Assistant | | | MEDICAL EXAMINER
DATE SIGNED 2/22/82 | | |
| EXAMINER'S NAME
(TYPE OR PRINT) Hormez R. Guard, M.D. | | | | | | ADDRESS
111 Penn St. Balto., MD. | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY) Burial | | | | 23b. DATE
2/26/82 | | 23c. NAME OF CEMETERY OR CREMATORY
Holy Rosary Cemetery | | | | 23d. LOCATION
CITY OR TOWN STATE
Dundalk Baltimore Md. | |
| 24. FUNERAL DIRECTOR
NAME ADDRESS
Hubbard Funeral Home, Inc. 4107 Wilkens Ave. 21229 | | | | | | 25a. DATE REC'D. BY REGISTRAR 25b. REGISTRAR'S SIGNATURE
FEB 23 1982 Frances J. [Signature] | | | | | |

BP





1. FOR
STATE
REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 2 0 3 9 2 9

REG. NO.

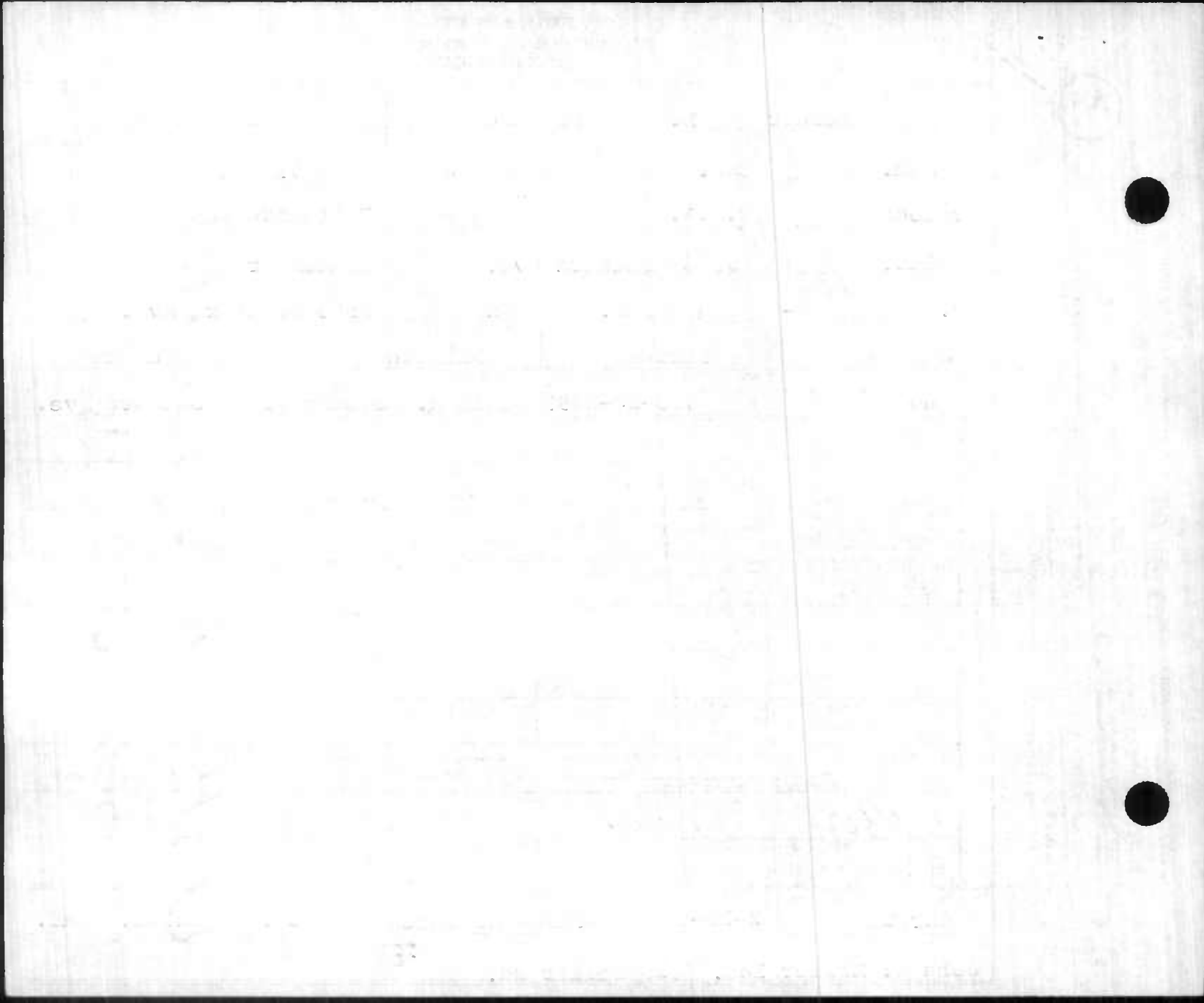
| | | | | | | | | | | |
|---|--|--|---|---|--|--|---|--|--|--|
| 1. DECEASED NAME
(TYPE OR PRINT)
Eleanor L. Kossman | | | 2a. DATE OF DEATH
MONTH DAY YEAR
2 11 82 | | | 2b. HOUR
M
M | | | | |
| 3. SEX
Fem. | | 4. RACE
Cau. | | 5. DATE OF BIRTH
MONTH DAY YEAR
4 3 02 | | 6. AGE (IN YEARS LAST BIRTHDAY)
YRS.
79 | | IF UNDER 1 YEAR
MONTHS DAYS HOURS MIN.
IF UNDER 24 HRS. | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
Arizona | | 7b. CITIZEN OF WHAT COUNTRY?
U.S.A. | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
Baltimore City | | | MD. | |
| 10. CITY OR TOWN OF DEATH
Balto. | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
3506 Southern Ave. | | | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
Homemaker | | 12b. KIND OF BUSINESS OR INDUSTRY | | |
| 13a. STATE
Md. | | | 13b. COUNTY
Balto. | | 13c. CITY OR TOWN
Balto. | | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS
3506 Southern Ave. | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
Julius Strauss | | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
Lillian Linette | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
no | | | 16b. SOCIAL SECURITY NO.
(IF YES, GIVE WAR OR DATES)
705-10-2499 | | 17. INFORMANT
ADDRESS
Lewis M. Kossman 3506 Southern Ave. | | | | | |

| | | | | | | | | | |
|--|--|--|--|--|---|--|--|--|--|
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART 1. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Probably cardiac arrest due to atherosclerosis - ?
4960
DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b) Heart failure due to (H)
(c) COPD
>6 years
>10 years | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:
P. T. B. E. depression. | | | | | | | | | |
| 19a. DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER NOTIFY MEDICAL EXAMINER) | | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK AT WORK | | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) lost
saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated
above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | |
| 27b. SIGNATURE
X Albert Nahum | | | | | | DEGREE
ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | 22c. DATE SIGNED
2/12/82 | |
| 27d. PHYSICIAN'S NAME (TYPE OR PRINT)
Albert Nahum, M.D. | | | | | | 27e. ADDRESS
120 N. Broadway
Baltimore, Md. 21231 | | | |
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)
Burial | | | 23b. DATE
2-15-82 | | 23c. NAME OF CEMETERY OR CREMATORY
Gardens of Faith | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
Balto. Balto. Md. | | |
| 24. FUNERAL DIRECTOR
NAME ADDRESS
John C. Miller Inc. 6415 Belair Rd. | | | | | | 25a. DATE REC'D BY REGISTRAR
FEB 16 1982 | | 25b. REGISTRAR'S SIGNATURE
James J. [Signature] | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.



TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

DHMH-16 30M 2/80
(VRA 15, 4)

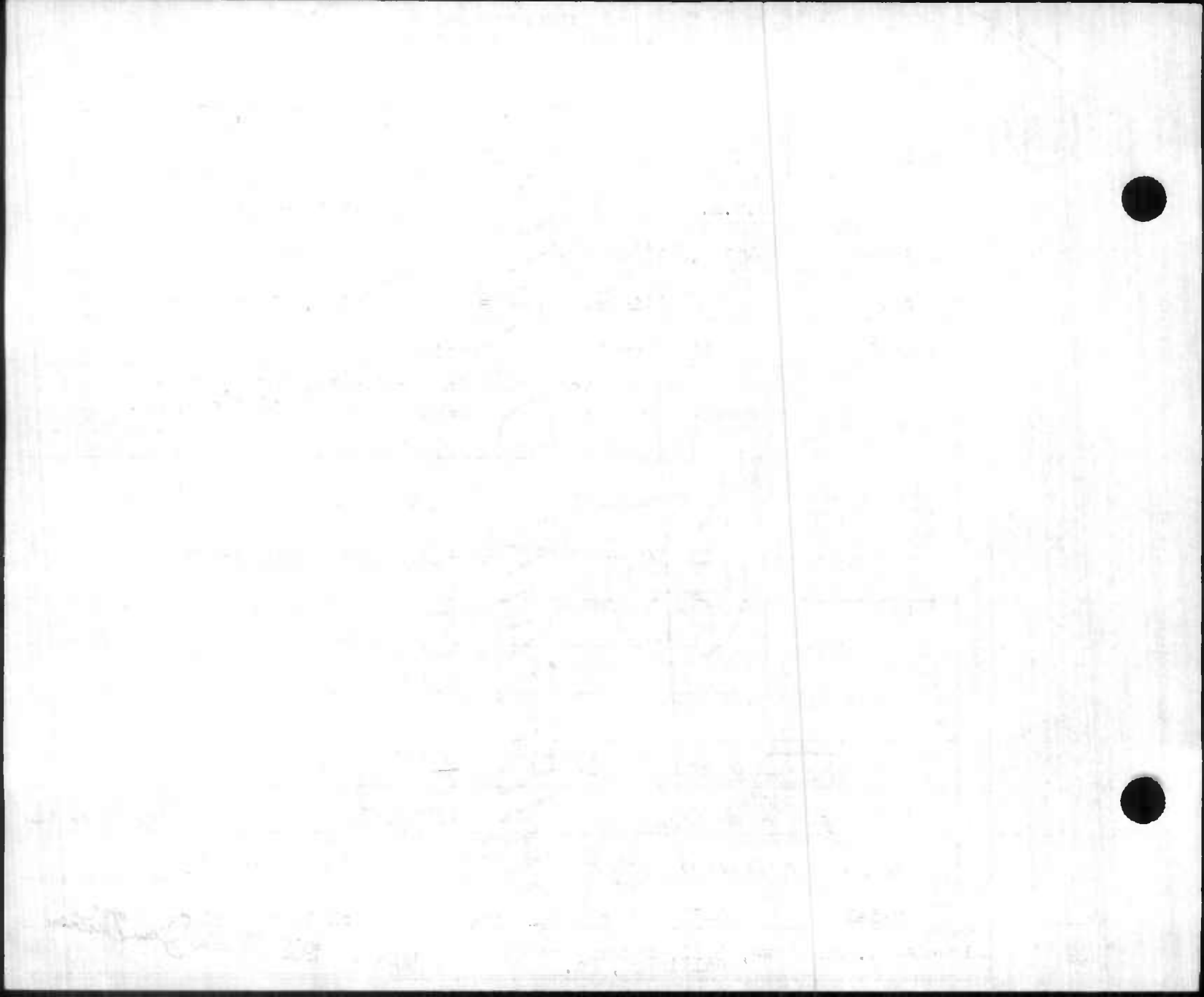
STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 2 0 3 9 3 0

REG. NO.

| | | | | | | | |
|--|--|---|--|---|--|--|--|
| 1. FOR STATE REGISTRAR | | 1. DECEASED NAME
(TYPE OR PRINT) | | 2a. DATE OF DEATH | | 2b. HOUR | |
| | | KYRIAKI KOUIMANIS | | February 20, 1982 | | 11:30P M | |
| 3. SEX
Female | | 4. RACE
White | | 5. DATE OF BIRTH
MONTH 8 DAY 28 YEAR 07 | | 6. AGE (IN YEARS LAST BIRTHDAY)
74 | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
Greece | | 7b. CITIZEN OF WHAT COUNTRY?
U.S.A. | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
Baltimore City MD | |
| 10. CITY OR TOWN OF DEATH
Baltimore | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
809 S. Oldham Street | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
Housewife | | 12b. KIND OF BUSINESS OR INDUSTRY
- | |
| 13a. STATE
Maryland | | 13b. COUNTY | | 13c. CITY OR TOWN
Baltimore | | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
Michael Pitsikoulis | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
Sophia Pritis | | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)
No | | 16b. SOCIAL SECURITY NO.
219-52-4195 | |
| | | 17. INFORMANT
Nicholas Kouimanis, 809 S. Oldham Street
Baltimore, Md. | | 17a. ADDRESS | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART 1. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>Probable sudden death due to aneurysm? F.H.M.O.P.</u>
<u>4149</u>
DUE TO, OR AS A CONSEQUENCE OF
(b) <u>CORONARY ART DISEASE</u>
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(c) <u>HYPERTENSION</u>
DUE TO, OR AS A CONSEQUENCE OF
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
<u>> 15 years</u>
<u>> 15 years</u> | | PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <u>110</u> | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> AT WORK
AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>6/6</u> , 19 <u>77</u> , to <u>present</u> , 19 <u>82</u> , that (I) (we) lost
saw the deceased alive on <u>11/30</u> , 19 <u>81</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated
above, (I) (we) (did) (did not) view the body after death. | | 22b. SIGNATURE
<u>Albert Nahum</u>
DEGREE
<u>M.D.</u> | | 22c. DATE SIGNED
<u>2/22/82</u> | | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
<u>ALBERT NAHUM, M.D.</u> | | 22e. ADDRESS
<u>100 N. BROADWAY</u> | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)
Burial | | 23b. DATE
2-24-82 | | 23c. NAME OF CEMETERY OR CREMATORY
Oak Lawn Cemetery | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
Baltimore Baltimore | |
| 24. FUNERAL DIRECTOR
Nicholas T. Matthews, 3021 Eastern Avenue
Baltimore, Md. | | 25a. DATE REC'D. BY REGISTRAR | | 25b. REGISTRAR'S SIGNATURE
<u>James J. [Signature]</u> | | | |

MAR 1 1982



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

FOR
1. STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

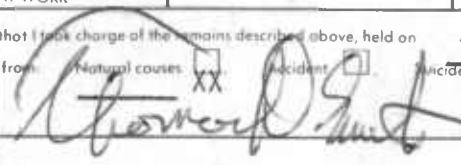

8 2 0 3 9 3 1

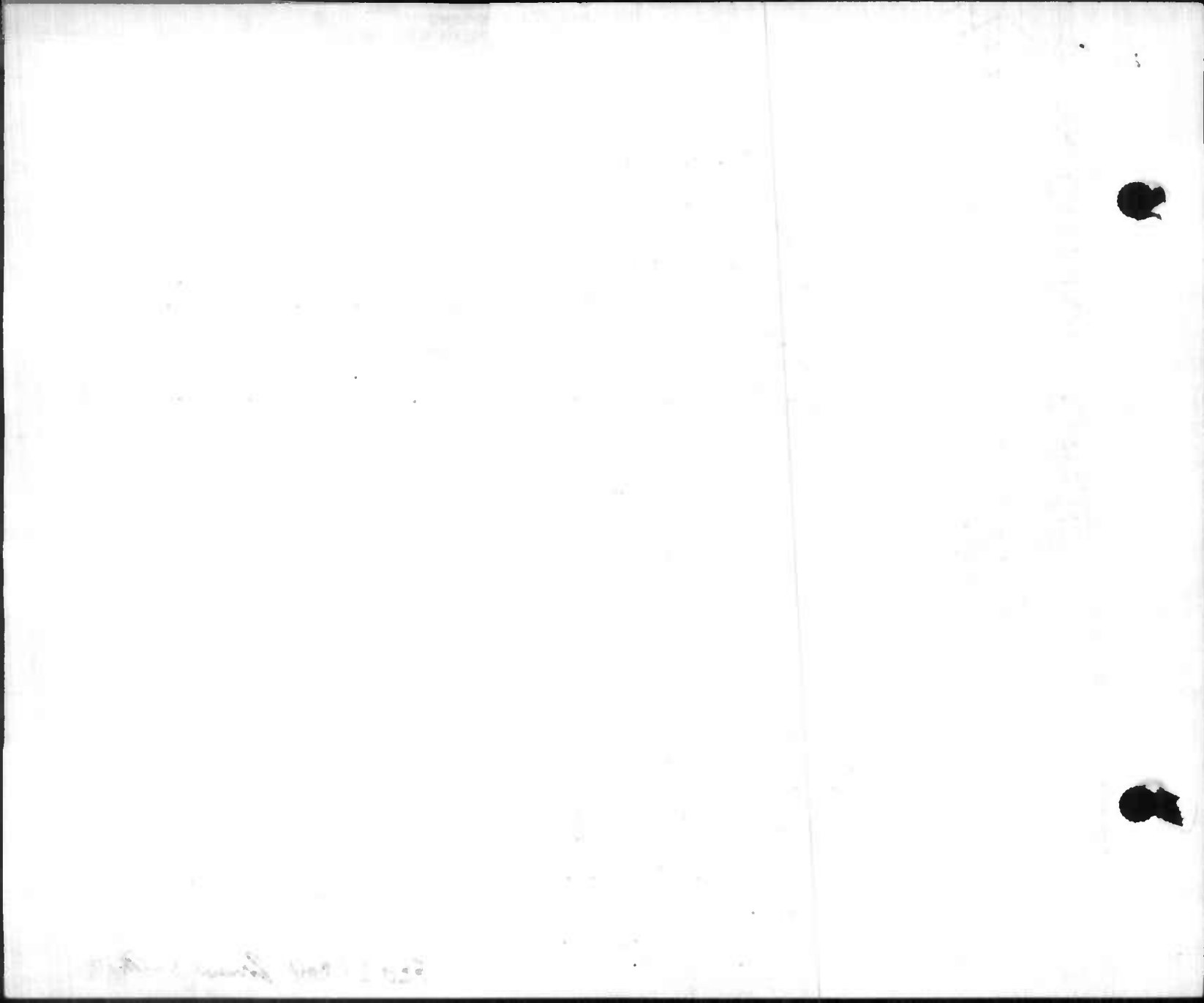
| | | | | | |
|--|--|---|--|---|---|
| 1. DECEASED NAME
(TYPE OR PRINT) GUSSIE KOVENS | | | 2a. DATE OF DEATH
MONTH 2 DAY 5 YEAR 82 2b. HOUR 0235A | | |
| 3. SEX
F FEMALE | 4. RACE
WHITE | 5. DATE OF BIRTH
MONTH 03 DAY 21 YEAR 88 | 6. AGE (IN YEARS LAST BIRTHDAY)
93 YRS | | IF UNDER 1 YEAR
MONTHS 0 DAYS 0 |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
RUSSIA | 7b. CITIZEN OF WHAT COUNTRY?
USA | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 9. BALTIMORE CITY OR COUNTY OF DEATH
BALTIMORE CITY, MD. | | |
| 10. CITY OR TOWN OF DEATH
BALTIMORE | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
SINAI HOSPITAL | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
HOUSEWIFE | 12b. KIND OF BUSINESS OR INDUSTRY
AT HOME | |
| 13a. STATE
MARYLAND | | | 13b. COUNTY | 13c. CITY OR TOWN
BALTIMORE | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |
| 14. FATHER'S NAME
FIRST ISRAEL MIDDLE BENDER LAST BENDER | | | 15. MOTHER'S MAIDEN NAME
FIRST BESSIE MIDDLE UNKNOWN LAST UNKNOWN | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
NO | | 16b. SOCIAL SECURITY NO.
220-44-4558 | 17. INFORMANT MR. SIDNEY KOVENS
7 SLADE AVE., APT. 118 BALTO., MD 21208 | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART 1. DEATH WAS CAUSED BY:
5304 IMMEDIATE CAUSE (a) CARDIAC FAILURE
DUE TO, OR AS A CONSEQUENCE OF
b) RESPIRATORY FAILURE
DUE TO, OR AS A CONSEQUENCE OF
c) MEDIASTINAL PERFORATION
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
1h
1h.
10 days. |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a):
GASTROINTESTINAL HEMORRHAGE. | | | | | |
| 19a. DATE OF OPERATION
1/28/82 | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED
ESOPHAGEAL PERFORATION | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input type="checkbox"/> | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | |
| 22a. I certify that (I, this hospital) attended the deceased from 1/24 , 19 82 , to 2/5 , 19 82 , that (I, we) last saw the deceased alive on 2/5 , 19 82 , and that in (my, our) opinion death occurred on the date and hour and from the causes stated above. (If we did not view the body after death.) | | | | | |
| 22b. SIGNATURE
Jordan K. Reed | | DEGREE
ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> | 22c. DATE SIGNED
2/5/82 | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
JORDAN K. REED | | 22e. ADDRESS
SINAI HOSPITAL OF BALTIMORE. | | | |
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY) BURIAL | 23b. DATE
FEB. 7, 1982 | 23c. NAME OF CEMETERY OR CREMATORY
SHAAREI TFILOH | 23d. LOCATION
CITY OR TOWN BALTIMORE COUNTY MARYLAND STATE MARYLAND | 25a. DATE REC'D. BY REGISTRAR FEB 11 1982 25b. REGISTRAR'S SIGNATURE Frances Jan Nathan | |
| 24. FUNERAL DIRECTOR SOL LEVINSON & BROS., INC.
NAME ADDRESS 6010 REISTERSTOWN RD. BALTO., MD 21215 | | | 25c. REGISTRAR'S SIGNATURE | | |



TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH. WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

MEDICAL CERTIFICATION

| STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH | | | | | | | | | | REG. NO. 5 2 0 3 9 3 2 | |
|--|--|---|--|---|--|---|--|---|--|--|--|
| 1. FOR STATE REGISTRAR | | | | | | | | | | | |
| 1. DECEASED NAME
(TYPE OR PRINT) FIRST MIDDLE LAST
Sidney Kronberg | | | | | | 2a. DATE KNOWN OF DEATH
ESTIMATED <input checked="" type="checkbox"/> MONTH DAY YEAR
2 6 19 82 | | 2b. HOUR
M | | | |
| 3. SEX
male | | 4. RACE
white | | 5. DATE OF BIRTH
MONTH DAY YEAR
MAR. 7, 1927 | | 6. AGE (IN YEARS)
LAST BIRTHDAY YRS.
54 | | IF UNDER 1 YR. MONTHS DAYS
IF UNDER 24 HRS. HOURS MIN. | | 2c. DATE PRONOUNCED DEAD
MONTH DAY YEAR
2 8 19 82 | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
MARYLAND | | 7b. CITIZEN OF WHAT COUNTRY?
USA | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
Baltimore City | | AM
AM | | | |
| 10. CITY OR TOWN OF DEATH
Baltimore | | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
111 W. Centre Street | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)
NONE | | 12b. KIND OF BUSINESS OR INDUSTRY
NONE | | | |
| USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) | | | | | | | | | | | |
| 13a. STATE
MARYLAND | | 13b. COUNTY | | 13c. CITY OR TOWN
BALTIMORE | | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS
APT. 1807
111 W. CENTRE ST. 21201 | | | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
SAMI KRONBERG | | | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
BESSIE GOLDSTEIN | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO, OR UNKNOWN)
YES | | | | 16b. SOCIAL SECURITY NO.
WWII-NAVY 217-22-8143 | | 17. INFORMANT MRS. BESSIE KRONBERG
2500 W. BELVEDERE AVE., APT. 713 #21215 | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I DEATH WAS CAUSED BY: Arteriosclerotic cardiovascular disease
4292 IMMEDIATE CAUSE (a) DUETO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.
(b) DUETO, OR AS A CONSEQUENCE OF
(c) | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I 18. | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | | | | 20. AUTOPSY?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | |
| 21a. EXTERNAL CAUSE WAS
UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH | | | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2) | | | | | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK AT WORK | | | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | | | |
| 22a. I certify that I took charge of the remains described above, held on death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> .
Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion | | | | | | | | | | | |
| ACTUAL SIGNATURE  | | | | TITLE (SPECIFY)
Deputy Chief | | | | MEDICAL EXAMINER | | | |
| EXAMINER'S NAME
(TYPE OR PRINT)
Thomas D. Smith, M.D. | | | | ADDRESS
111 Penn Street, Balto MD 21201 | | | | DATE SIGNED
2/8/82 | | | |
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)
BURIAL | | | | 23b. DATE
FEB. 10, 1982 | | 23c. NAME OF CEMETERY OR CREMATORY
OHR KNESSETH ISRAEL ANSHE SPARD | | 23d. LOCATION
BALTIMORE | | MARYLAND | |
| 24. FUNERAL DIRECTOR SOL LEVINSON & BROS., INC.
NAME ADDRESS
6010 REISTERSTOWN RD. BALTO., MD 21215 | | | | | | 25a. DATE REC'D. BY REGISTRAR
FEB 17 1982 | | 25b. REGISTRAR'S SIGNATURE
 | | | |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked as item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

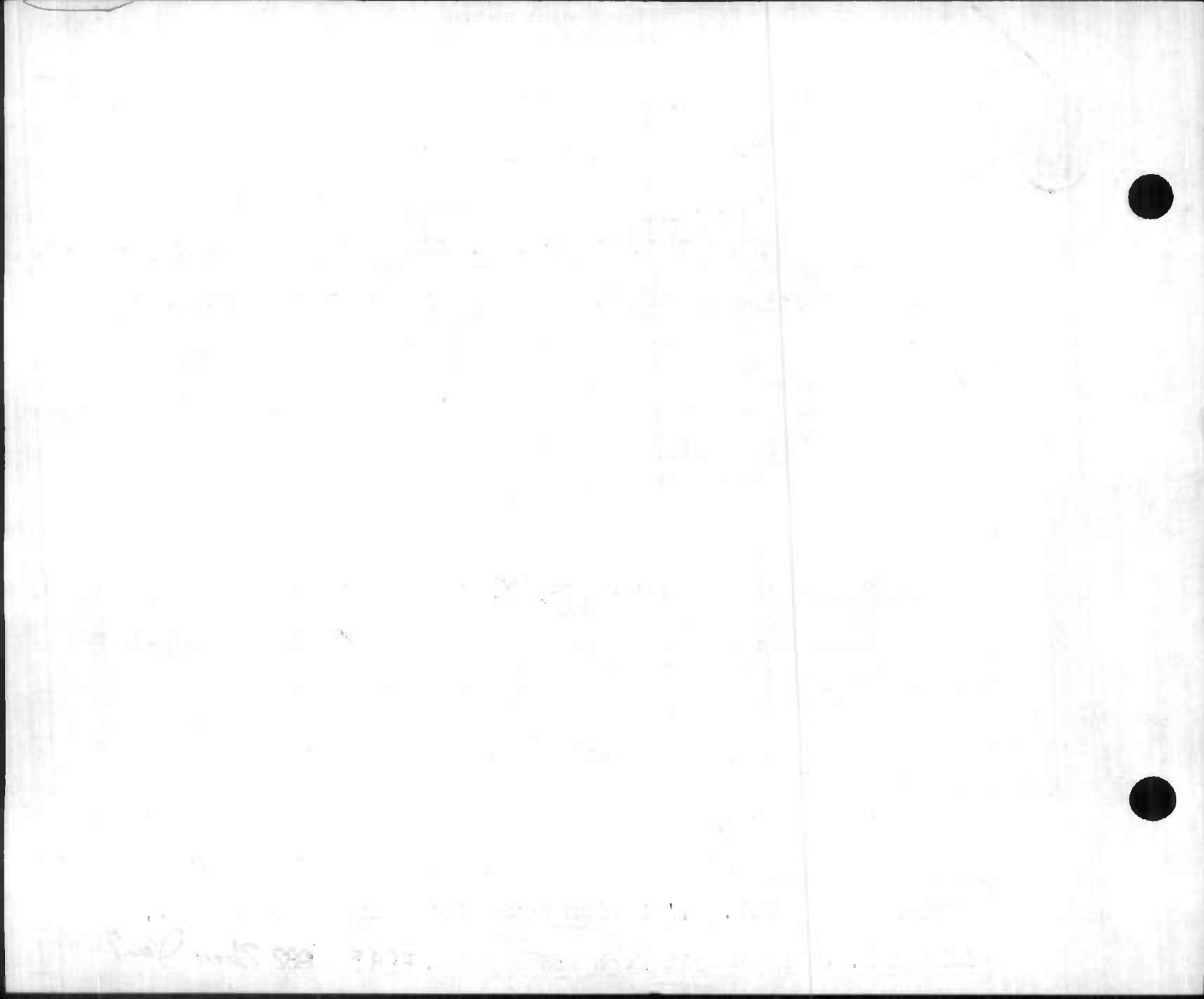
STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 2 0 3 9 3 3

REG. NO.

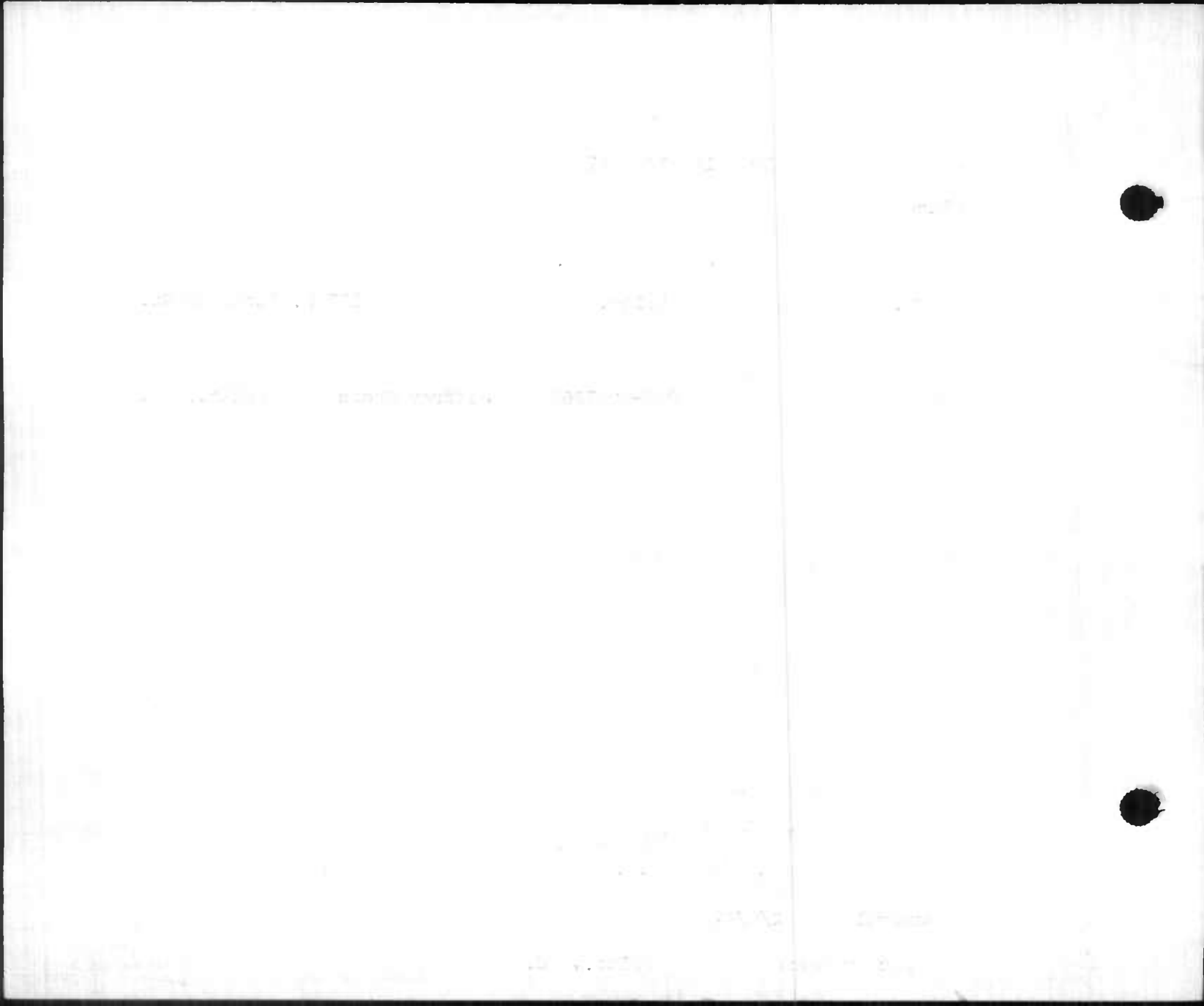
| | | | | | | | | |
|--|--|--|--|--|--|---|--|--|
| 1. FOR STATE REGISTRAR | | | 2a. DATE OF DEATH | | | 2b. HOUR | | |
| 1. DECEASED NAME (TYPE OR PRINT) | | | 2a. DATE OF DEATH | | | 2b. HOUR | | |
| FIRST MIDDLE LAST
ANDREW J. KRUZEL | | | MONTH DAY YEAR
FEB. 4 82 | | | 10:45A M | | |
| 3. SEX
MALE | | | 4. RACE
WHITE | | | 5. DATE OF BIRTH | | |
| 6. AGE (IN YEARS LAST BIRTHDAY) | | | 7. CITIZEN OF WHAT COUNTRY? | | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | |
| 9. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
PENNSYLVANIA | | | 10. CITY OR TOWN OF DEATH
BALTIMORE | | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
VAMC, LOCH RAVEN BALTO. MD. 21218 | | |
| 12a. USUAL OCCUPATION (TYPE OF WORK OR WORKING LIFE)
CARPENTER | | | 12b. KIND OF BUSINESS OR INDUSTRY
Construction | | | 13a. STREET ADDRESS
1921 WILDWOOD AVE. 21234 | | |
| 13a. STREET ADDRESS | | | 13b. CITY OR TOWN | | | 13c. INSIDE CITY LIMITS?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
ANDREW KRUZEL | | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
KATHERINE CYERWINSKA | | | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
YES <input checked="" type="checkbox"/> OR UNKNOWN <input type="checkbox"/> (IF YES, STATE OR DATES)
WWII | | |
| 16b. SOCIAL SECURITY NO.
189 05 3583 | | | 17. INFORMANT
ADDRESS
Anna B. Kruzel Baltimore, MD 21234 | | | 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART 1. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>HYPOXEMIA</u>
<u>4920</u>
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.
(b) <u>RESPIRATORY FAILURE</u>
(c) <u>EMPHYSEMA</u> | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:
<u>STAPHYLOCOCCUS AUREUS - ENTEROCOCCUS ENDOCARDITIS / GASTROENTERITIS</u> | | | | | | | | |
| 19a. DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | |
| 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | | 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | |
| 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | 21d. INJURY OCCURRED
WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | |
| 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | 22a. DATE SIGNED
3/4/82 | | | 22b. SIGNATURE
J.M. WOGAN M.D. | | |
| 22c. DATE SIGNED | | | 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
J.M. WOGAN M.D. | | | 22e. ADDRESS
3900 LOCH RAVEN BLVD. BALTIMORE, MD 21218 | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)
Burial | | | 23b. DATE
Feb. 8, '82 | | | 23c. NAME OF CEMETERY OR CREMATORY
Zion Methodist Church Carroll Co., MD | | |
| 23d. LOCATION
CITY OR TOWN COUNTY STATE | | | 24. FUNERAL DIRECTOR
NAME
William E. Johnson | | | 25a. DATE REC'D. BY REGISTRAR
FEB 5 1982 | | |
| 25b. REGISTRAR'S SIGNATURE
Theresa Van Natten | | | 25c. REGISTRAR'S NAME
Theresa Van Natten | | | 25d. REGISTRAR'S ADDRESS
8521 Loch Raven Blvd. | | |

BP



TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, THE MEDICAL EXAMINER SHOULD EXECUTE THE CERTIFICATE, WRITING TO THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. GIVE PAGES 4 AND 5 TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 17 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

| STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH | | | | | | | | | | | | REG. NO. 6 2 0 3 9 3 4 | | | |
|--|--|------------------|--|--|--|--|--|---|--|-----------------------------|--|--|--|----------------------|--|
| 1- FOR STATE REGISTRAR | | | | | | | | | | | | 2a. DATE KNOWN OF DEATH | | 2b. HOUR | |
| 1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST
ALFRED L. KWASNIEWSKI | | | | | | | | | | | | ESTIMATED <input checked="" type="checkbox"/> MONTH DAY YEAR
2 3 19 82 | | 2b. HOUR
9:55 P M | |
| 3. SEX
male | | 4. RACE
white | | 5. DATE OF BIRTH MONTH DAY YEAR
10 18 14 | | 6. AGE (IN YEARS LAST BIRTHDAY)
67 YRS. | | IF UNDER 1 YR. MONTHS DAYS | | IF UNDER 24 HRS. HOURS MIN. | | 2c. DATE PRONOUNCED DEAD MONTH DAY YEAR
2 5 19 82 | | 2d. HOUR
9:55 P M | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
Poland | | | | 7b. CITIZEN OF WHAT COUNTRY? | | | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | | | 9. BALTIMORE CITY OR COUNTY OF DEATH
Baltimore City MD | | | |
| 10. CITY OR TOWN OF DEATH
Baltimore | | | | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
117 N. Streeper St. | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | | | | 12b. KIND OF BUSINESS OR INDUSTRY | | | |
| USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) | | | | | | | | | | | | | | | |
| 13a. STATE
Md. | | 13b. COUNTY | | 13c. CITY OR TOWN
Balto. | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS
117 N. Streeper St. | | | | | | | |
| 14. FATHER'S NAME FIRST MIDDLE LAST | | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST | | | | | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)
No | | | | 16b. SOCIAL SECURITY NO.
044-10-7262 | | | | 17. INFORMANT
Jeffrey Shere | | | | ADDRESS
Balto., Md. | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I DEATH WAS CAUSED BY:
1629 IMMEDIATE CAUSE (a) <u>Carcinoma of lung</u>
Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last:
(b) _____
(c) _____
DUE TO, OR AS A CONSEQUENCE OF
DUE TO, OR AS A CONSEQUENCE OF | | | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) | | | | | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | | | | | | | | 20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH | | | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR
P.M. 19 | | | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) | | | | | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK AT WORK | | | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) | | | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | | | | | |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> . | | | | | | | | | | | | | | | |
| ACTUAL SIGNATURE | | | | TITLE (SPECIFY)
M.D. Assistant MEDICAL EXAMINER | | | | | | | | DATE SIGNED 2-6-82 | | | |
| EXAMINER'S NAME (TYPE OR PRINT)
Ann M. Dixon, M.D. | | | | ADDRESS
111 Penn St. | | | | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)
Removal | | | | 23b. DATE
2/8/82 | | | | 23c. NAME OF CEMETERY OR CREMATORY | | | | 23d. LOCATION CITY OR TOWN COUNTY STATE | | | |
| 24. FUNERAL DIRECTOR NAME
Anatomy Board | | | | ADDRESS
Balto., Md. | | | | 25a. DATE REC'D. BY REGISTRAR
FEB 6 3 1982 | | | | 25b. REGISTRAR'S SIGNATURE | | | |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the death certificate with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be called.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 2 0 3 9 3 5

1- FOR
STATE
REGISTRAR

REG. NO.

| | | | | | |
|--|--|---|---|--|---|
| 1. DECEASED NAME
(TYPE OR PRINT)
FIRST MIDDLE LAST
WILLIAM G. LACKINGTON | | 2a. DATE OF DEATH
MONTH DAY YEAR
2 12 82 | | 2b. HOUR
1:40 P.M. | |
| 3. SEX
M | 4. RACE
White | 5. DATE OF BIRTH
MONTH DAY YEAR
7 25 28 | | 6. AGE (IN YEARS LAST BIRTHDAY)
53 YRS. | |
| 7a. BIRTHPLACE
(STATE OR FOREIGN COUNTRY)
N.Y. | 7b. CITIZEN OF WHAT COUNTRY?
U.S.A. | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
CITY MD. | |
| 10. CITY OR TOWN OF DEATH
BALTO. | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
S. B. G. H. | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
Manager | | 12b. KIND OF BUSINESS OR INDUSTRY
Grocery |
| 13a. STATE
Md. | | 13b. CITY OR TOWN
LINTHICUM | 13c. INSIDE CITY LIMITS?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | 13e. STREET ADDRESS
418 Hillview Dr, Apt 302 | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
CHARLES LACKINGTON | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
Unknown | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
Yes | | 16b. SOCIAL SECURITY NO.
(IF YES, GIVE WAR OR DATES)
1947-50 | 17. INFORMANT
ADDRESS
Margaret M. Lackington, Same as 13e | | |
| 18. CAUSE OF DEATH: Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) 4300
DUE TO, OR AS A CONSEQUENCE OF (b) Rupture arterial aneurysm, left carotid.
DUE TO, OR AS A CONSEQUENCE OF (c) Atherosclerosis, severe, generalized. | | | | | APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATH |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)
COPD | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK AT WORK | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | |
| 22a. I certify that (I) (this hospital) attended the deceased from 2/11 19 82, to 2/12 19 82, that (I) (we) last saw the deceased alive on 2/12 19 82 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | |
| 22b. SIGNATURE
Steven Rapp | | DEGREE | | 22c. DATE SIGNED
2/12/82 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
STEVEN RAPP | | 22e. ADDRESS
S. B. G. H. | | | |
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)
Burial | | 23b. DATE
2/15/82 | | 23c. NAME OF CEMETERY OR CREMATORY
Cedar Hill Cem. | |
| 23d. LOCATION
CITY OR TOWN
Baltimore | | 23e. COUNTY
A.A. Md | | 23f. STATE | |
| 24. FUNERAL DIRECTOR
NAME
George J. Gonce, 4001 Ritchie Hwy | | ADDRESS
Balto, Md | | 25a. DATE RECD. BY REGISTRAR
FEB 16 1982 | |

BP



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon copies. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be called at once.

DHMH-16 50M 1/81
(VRA 15, 4)1 - FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 2 0 3 7 3 6

REG. NO.

| | | | | | | |
|---|--|--|--|--|----------------------------|--|
| 1. DECEASED NAME
(TYPE OR PRINT)
FIRST MIDDLE LAST
IRIS M LACOLLA | | | 2a. DATE OF DEATH
MONTH DAY YEAR
02-01-82 | | 2b. HOUR
9:03 PM | |
| 3. SEX
FEMALE | | 4. RACE
WHITE | | 5. DATE OF BIRTH
MONTH DAY YEAR
02-16-01 | | |
| 6. AGE (IN YEARS, LAST BIRTHDAY)
80 | | 7. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
MARYLAND | | 8. CITIZEN OF WHAT COUNTRY?
USA | | |
| 9. BALTIMORE CITY OR COUNTY OF DEATH
CITY | | 10. CITY OR TOWN OF DEATH
BALTIMORE | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
SBGH | | |
| 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
RETIRED | | 12b. KIND OF BUSINESS OR INDUSTRY | | 13. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
HOWARD SWIFT | | 15. MOTHER'S MAIDEN NAME
FIRST LAST
IDA TENNEYSON | | 16. SOCIAL SECURITY NO.
215 05 1146 | | |
| 17. INFORMANT
ADDRESS
Michael Marino, 184 W. Meadow Rd. (21225) | | 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART 1. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) CARDIOGENIC SHOCK
DUE TO, OR AS A CONSEQUENCE OF
(b) ANTEROLATERAL MI - ACUTE
DUE TO, OR AS A CONSEQUENCE OF
(c) ASCVD
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | |
| 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | |
| 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK AT WORK | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | |
| 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | 22a. I certify that (i) (this hospital) attended the deceased from 02-01-82 to 02-01-82 that (i) (we) last saw the deceased alive on 02-01-82 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (i) (we) (did) (did not) view the body after death. | | 22b. SIGNATURE
Alex Kosenko | | |
| 22c. DEGREE
ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> | | 22d. DATE SIGNED
02-01-82 | | 22e. ADDRESS
3001 S. HANOVER ST. 21230 | | |
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)
BURIAL | | 23b. DATE
2/4/1982 | | 23c. NAME OF CEMETERY OR CREMATORY
CEDAR HILL | | |
| 23d. LOCATION
BROOKLYN HGTS., A.A.CO., MD. | | 24. FUNERAL DIRECTOR
George J. Gonce, 4001 Ritchie Hg., Baltimore, Md. | | 25a. DATE REC'D. BY REGISTRAR
FEB 5 1982 | | |
| 25b. REGISTRAR'S SIGNATURE
Frances Jan Nathan | | | | | | |

MEDICAL CERTIFICATION

2012

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10/10/12

10/10/12

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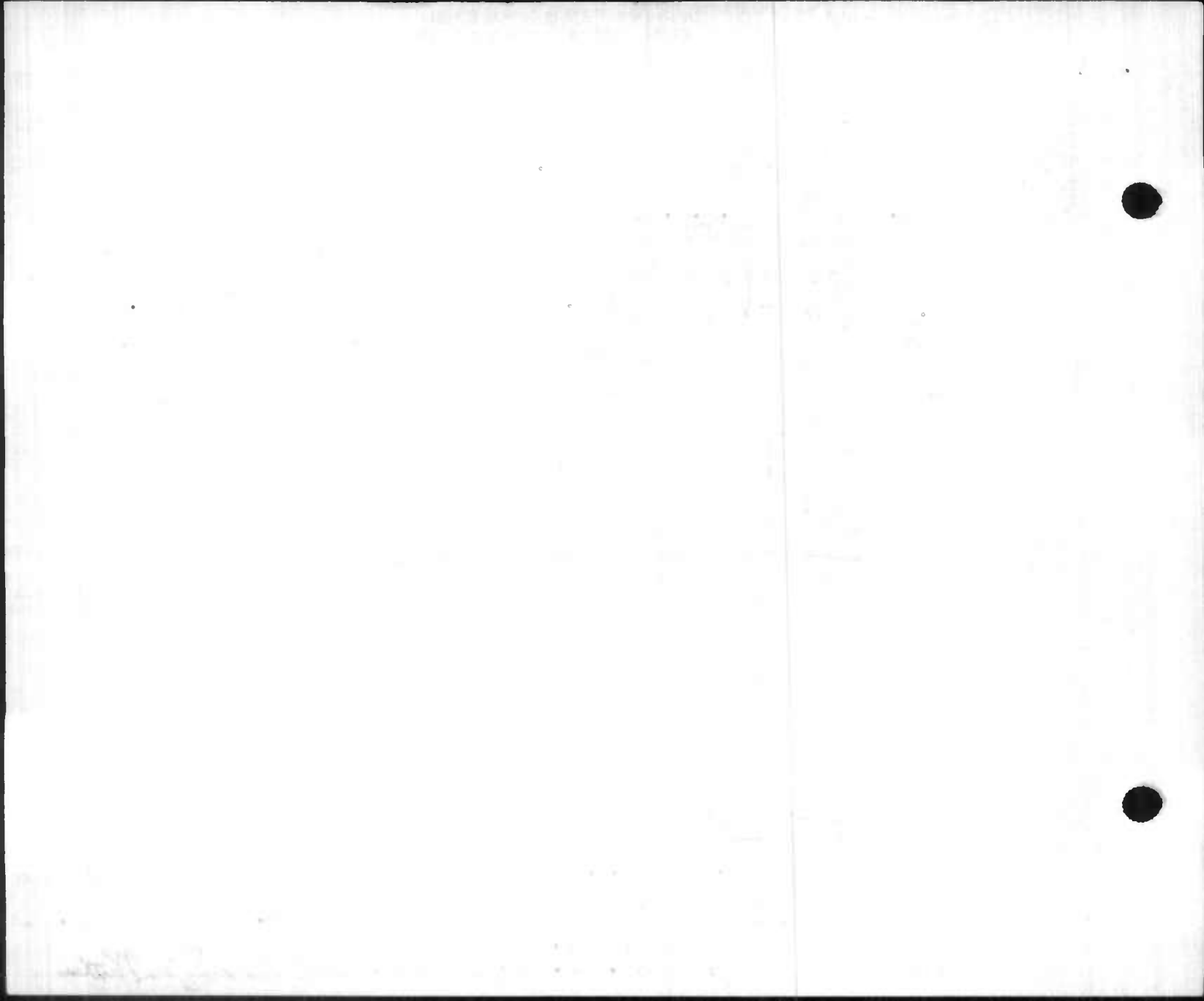
10/10/12

10/10/12

10/10/12

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 IN YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED IN DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

| Items #18a-22a Film G565 3/30/82 re STATE OF MARYLAND | | | | | | | | | |
|--|---------|--|---|------------------------------------|---|---|--|---|--|
| 1- STATE REGISTRAR | | | | | | | | | |
| DEPARTMENT OF HEALTH AND MENTAL HYGIENE | | | | | | | | | |
| MEDICAL EXAMINER'S CERTIFICATE OF DEATH | | | | | | | | | |
| REG. NO. 2 0 3 9 3 7 | | | | | | | | | |
| 1. DECEASED NAME
(TYPE OR PRINT) | | | | | | 2a. DATE KNOWN OF DEATH | | 2b. HOUR | |
| FIRST MIDDLE LAST
Stephen Anthony LaCourse | | | | | | MONTH DAY YEAR
2 28 19 82 | | M
AM | |
| 3. SEX | 4. RACE | 5. DATE OF BIRTH | | 6. AGE (IN YEARS) | IF UNDER 1 YR. | | IF UNDER 24 HRS. | | 7c. DATE PRONOUNCED DEAD |
| male | white | MONTH DAY YEAR
4/26/81 | | LAST BIRTHDAY
10 Mo. | MONTHS DAYS HOURS MIN. | | | | MONTH DAY YEAR
2 28 19 82 |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) | | 7b. CITIZEN OF WHAT COUNTRY? | | | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH | |
| Md. | | U.S.A. | | | | | | Baltimore City MD. | |
| 10. CITY OR TOWN OF DEATH | | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | | 12b. KIND OF BUSINESS OR INDUSTRY | |
| Baltimore | | Union Memorial Hospital | | | | - | | - | |
| USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) | | | | | | | | | |
| 13a. STATE | | 13b. COUNTY | | 13c. CITY OR TOWN | | 13d. INSIDE CITY LIMITS? | | 13e. STREET ADDRESS | |
| Md. | | - | | Balto. | | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 3610 Woodlea Ave. | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST | | | | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST | | | | |
| Richard LaCourse | | | | | Nancy Burck | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO, OR UNKNOWN) | | | | 16b. SOCIAL SECURITY NO. | | 17. INFORMANT ADDRESS | | | |
| - | | | | - | | same address
Richard LaCourse (father) | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I DEATH WAS CAUSED BY: | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| IMMEDIATE CAUSE (a) <u>Acute infarction of kidney</u> | | | | | | | | | |
| 7532 } DUE TO, OR AS A CONSEQUENCE OF | | | | | | | | | |
| Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. | | | | | | | | | |
| (b) <u>hydronephrosis from a congenital ureteric stenosis</u> | | | | | | | | | |
| (c) _____ | | | | | | | | | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a). | | | | | | | | | |
| 19a. DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | | | | | 20. AUTOPSY? | |
| | | | | | | | | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. EXTERNAL CAUSE WAS
UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH | | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) | | | | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK AT WORK | | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | | |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> . | | | | | | | | | |
| ACTUAL SIGNATURE | | | TITLE (SPECIFY) | | | | | DATE SIGNED | |
| <i>Hormez R. Guard</i> | | | M.D. Assistant MEDICAL EXAMINER | | | | | 2/28/82 | |
| EXAMINER'S NAME
(TYPE OR PRINT) | | | ADDRESS | | | | | | |
| Hormez R. Guard, M.D. | | | 111 Penn Street, Balto., MD 21201 | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY) | | 23b. DATE | | 23c. NAME OF CEMETERY OR CREMATORY | | | 23d. LOCATION
CITY OR TOWN COUNTY STATE | | |
| Burial | | 3/3/82 | | Parkwood Cemetery | | | Balto., MD. | | |
| 24. FUNERAL DIRECTOR
NAME ADDRESS | | | | 25a. DATE REC'D. BY REGISTRAR | | | 25b. REGISTRAR'S SIGNATURE | | |
| Schimunek Funeral Home, Inc.
3331 Brehms Lane, Balto., Md. 21213 | | | | MAR 3 1982 | | | <i>James J. Walker</i> | | |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 1 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the funeral director with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be consulted.

STATE OF MARYLAND

DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | |
|--|--|--|--|--|-----------------------------------|
| 1. DECEASED NAME
(TYPE OR PRINT) | | 2a. DATE OF DEATH | | 2b. HOUR | |
| Henry Charles Ladzinski | | 2/27/82 | | 1:40 A.M. | |
| 3 SEX | 4 RACE | 5. DATE OF BIRTH | | 6. AGE (IN YEARS LAST BIRTHDAY) | |
| male | white | 10 24 1912 | | 69 YRS. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) | 7b. CITIZEN OF WHAT COUNTRY? | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH | |
| Maryland | U.S.A. | | | Baltimore City MD. | |
| 10. CITY OR TOWN OF DEATH | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | | 12b. KIND OF BUSINESS OR INDUSTRY |
| Baltimore | St. Agnes Hospital | | Die Setter | | Solo Cup Co. |
| 13a. STATE | 13b. COUNTY | 13c. CITY OR TOWN | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | 13e. STREET ADDRESS | |
| Maryland | Baltimore | | | 2135 Monumental Avenue | |
| 14. FATHER'S NAME | | 15. MOTHER'S MAIDEN NAME | | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) | |
| John Ladzinski | | Amelia Bartokowski | | No | |
| 16b. SOCIAL SECURITY NO. | | 17. INFORMANT | | 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 5728 Shock | |
| 214-03-2587 | | Helen Loss | | DUE TO, OR AS A CONSEQUENCE OF (b) Septis and cardrogenic | |
| | | | | DUE TO, OR AS A CONSEQUENCE OF (c) Hepatic failure | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | | | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | |
| 22a. I certify that (I) (this hospital) attended the deceased from 2/22 1982, to 2/27 1982, that (I) (we) last saw the deceased alive on 2/27 1982, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | |
| 22b. SIGNATURE | | DEGREE | | 22c. DATE SIGNED | |
| BICH T DUONG | | M.D. | | 2/27/82 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) | | 22e. ADDRESS | | | |
| BICH T DUONG | | ST AGNES HOSPITAL | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) | | 23b. DATE | | 23c. NAME OF CEMETERY OR CREMATORY | |
| Burial | | 3/2/1982 | | Holy Rosary | |
| 24. FUNERAL DIRECTOR NAME | | 24b. DATE REC'D. BY REGISTRAR | | 25a. REGISTRAR'S SIGNATURE | |
| Duda-Ruck, Inc. | | MAR 2 1982 | | James J. Nathan | |
| 7922 Wise Avenue Dundalk, Md. 21222 | | | | | |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be called.

Items #5&6 Film G564 2/26/82 re

STATE OF MARYLAND

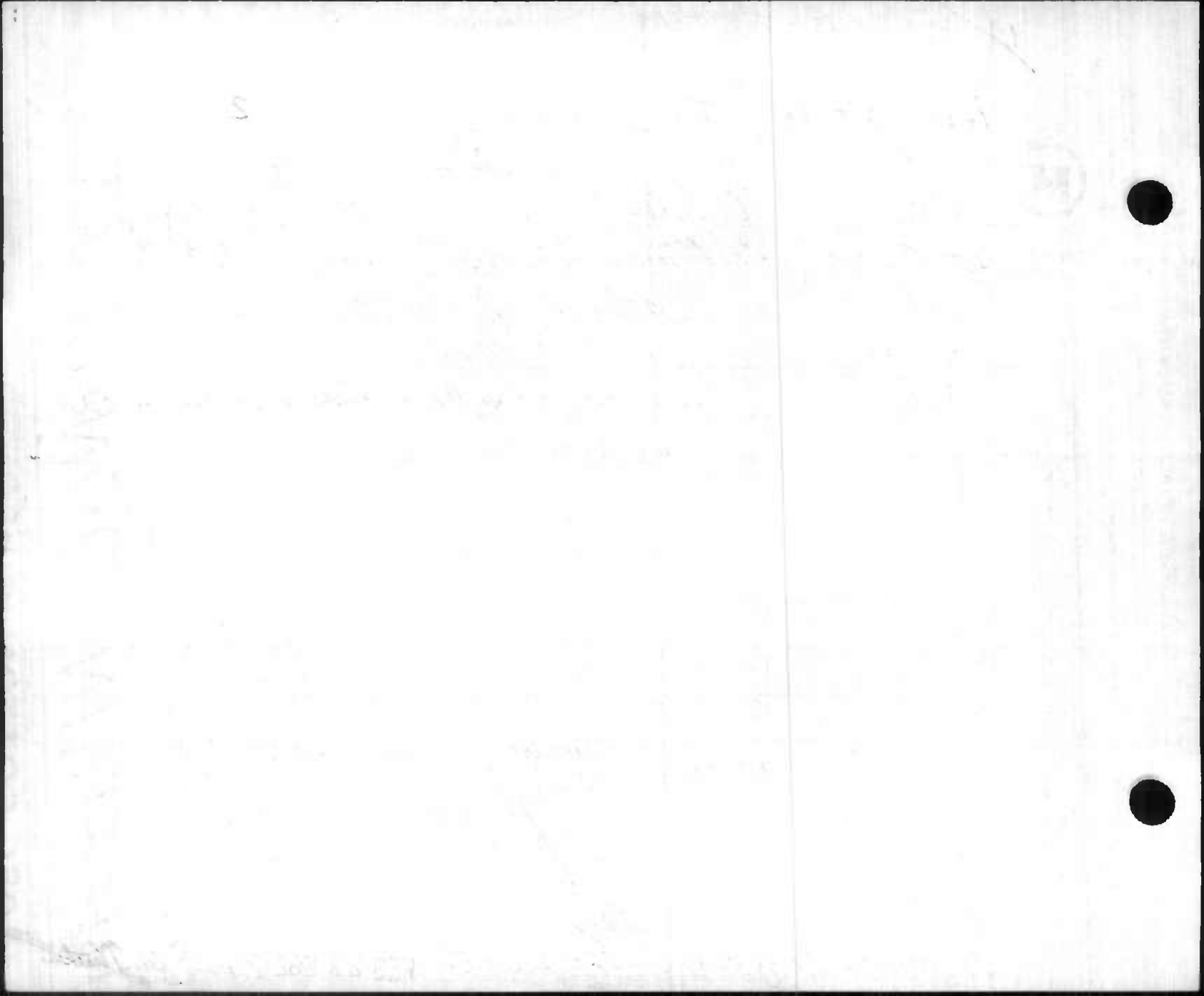
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 2 0 3 9 3 9

1 - STATE
REGISTRAR

REG. NO.

| | | | | | | |
|--|--|---|---|--|--|---|
| 1. DECEASED NAME
(SPP OR PRINT)
KATHERINE SABELL I. LAMARCO | | | 2a. DATE OF DEATH
MONTH DAY YEAR
2/20/82 | | 2b. HOUR
10:20 A | |
| 3. SEX
F | 4. RACE
W | 5. DATE OF BIRTH
MONTH DAY YEAR
1 24 1914 | | 6. AGE (IN YEARS LAST BIRTHDAY)
68 YRS | IF UNDER 1 YEAR
MONTHS DAYS
IF UNDER 24 HRS
HOURS MIN. | |
| 7a. BIRTHPLACE
(STATE OR FOREIGN)
Md. | 7b. CITIZEN OF WHAT COUNTRY?
U.S.A. | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
Baltimore City MD | | |
| 10. CITY OR TOWN OF DEATH
Baltimore | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
Baltimore City Hosp. | | 12. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
Domestic | | 13. KIND OF BUSINESS OR INDUSTRY
Home | |
| 14. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)
14a. STATE Md. | 14b. COUNTY
Baltimore | 14c. CITY OR TOWN
Baltimore | 14d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | 14e. STREET ADDRESS
325 Suzanne Ave | | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
Froy Smith | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
Hellie | | 16. ADDRESS
Rose Marie Thomas 6854 Dunbar Rd. | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES NO OR UNKNOWN)
No | | 16b. SOCIAL SECURITY NO.
212-20-0270 | | 17. INFORMANT
Rose Marie Thomas | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART 1. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) metastatic colon c.a.
1539
DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b) _____
DUE TO, OR AS A CONSEQUENCE OF
(c) _____ | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: _____ | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input type="checkbox"/> | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | |
| 21d. INJURY OCCURRED
WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | |
| 22a. I certify that (X) (this hospital) attended the deceased from 1/10/82 , 19____, to 2/20/82 , 19____, that (I) (we) last saw the deceased alive on 2/20/82 , 19____, and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death. | | | | | | |
| 22b. SIGNATURE
D. Drucikman M.D. | | | | DEGREE
ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> | | 22c. DATE SIGNED
2/20/82 |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
D. DRUCIKMAN, M.D., MPH | | | | 22e. ADDRESS
BALTIMORE CITY HOSP | | |
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)
Burial | | 23b. DATE
2.23.82 | | 23c. NAME OF CEMETERY OR CREMATORY
Holy Redeemer | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
Baltimore City Md. |
| 24. FUNERAL DIRECTOR
NAME
Raymond L. Kucynski | | | | 25a. DATE REC'D. BY REGISTRAR
FEB 22 1982 | | 25b. REGISTRAR'S SIGNATURE
James J. Nathan |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. People may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon copies. Pages 1 and 2 should be filed within 72 hours with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

| STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH | | | | REG. NO. | | | |
|--|--|---|--|--|--|---|---|
| 1. DECEASED NAME (TYPE OR PRINT) JAMES V. LAMBIASI Jr. | | | | 2a. DATE OF DEATH MONTH DAY YEAR 02-26-82 2b. HOUR 2:32 AM | | | |
| 3. SEX Male | | 4. RACE White | | 5. DATE OF BIRTH MONTH DAY YEAR May 12, 1911 | | 6. AGE (IN YEARS LAST BIRTHDAY) 70 YRS. IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) N.Y. | | 7b. CITIZEN OF WHAT COUNTRY? U.S.A. | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City MD | |
| 10. CITY OR TOWN OF DEATH Baltimore | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Good Samaritan Hospital | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Steam Fitter | | 12b. KIND OF BUSINESS OR INDUSTRY Liquor | |
| 13a. STATE Md. | | 13b. COUNTY Baltimore | | 13c. CITY OR TOWN Arbutus | | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 13e. STREET ADDRESS 5543 Ashbourne Rd. 21227 | | 14. FATHER'S NAME FIRST MIDDLE LAST James V. Lambiasi | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Lucy Pierce | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) no | | 16b. SOCIAL SECURITY NO. 216-09-6706 | | 17. INFORMANT ADDRESS Eleanor F. Lambiasi (same as 13e) | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiorespiratory arrest. 7302 DUE TO, OR AS A CONSEQUENCE OF (b) DUE TO, OR AS A CONSEQUENCE OF (c) | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 1/2 Hr. |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) Hypertension Diabetes Mellitus | | | | | | | |
| 19a. DATE OF OPERATION 2/17/82 | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED Osteoarthritis Rt. Hip | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER) <input type="checkbox"/> | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 2/15/82 to 2/26/82 that (I) (we) lost saw the deceased alive on 2/25/82 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | |
| 22b. SIGNATURE R. F. Davis | | | | DEGREE ATTENDING PHYSICIAN MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | 22c. DATE SIGNED 2/26/82 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) R. F. DAVIS | | | | 22e. ADDRESS 5601 Loch Raven Blvd. Baltimore, Md. | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Entombment | | 23b. DATE 3/1/1982 | | 23c. NAME OF CEMETERY OR CREMATORY Louden Park | | 23d. LOCATION CITY OR TOWN COUNTY STATE Baltimore, Md. | |
| 24. FUNERAL DIRECTOR NAME George J. Gonce F.H. 4001 Ritchie Hwy. ADDRESS Balto. Md. 21225 | | | | 25a. DATE REC'D. BY REGISTRAR MAR 1 1982 | | 25b. REGISTRAR'S SIGNATURE Anna J. [Signature] | |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with information from the death record with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

3

1- FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 2 0 3 9 4 1

REG. NO.

| | | | | | | | |
|---|--|--|--|---|--|--|--|
| 1. DECEASED NAME
(TYPE OR PRINT) FIRST MIDDLE LAST
Mary C. Lance | | | 2a. DATE OF DEATH MONTH DAY YEAR
2/22/82 | | | 2b. HOUR
M | |
| 3. SEX
female | | 4. RACE
black | | 5. DATE OF BIRTH
MONTH DAY YEAR
8/11/23 | | 6. AGE (IN YEARS LAST BIRTHDAY)
58 YRS. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
VA | | 7b. CITIZEN OF WHAT COUNTRY?
USA | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
Baltimore City MD. | |
| 10. CITY OR TOWN OF DEATH
Baltimore | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
1101 Orleans St. | | | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
housewife | |
| 13a. STATE
MD | | 13b. COUNTY | | 13c. CITY OR TOWN
Baltimore | | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
Henry Jones | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
Hattie Eckels | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
no | | 16b. SOCIAL SECURITY NO.
219-22-3005 | | 17. INFORMANT ADDRESS
Margaret Jackson 249 Aisquith St. | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART 1. DEATH WAS CAUSED BY:
1629 IMMEDIATE CAUSE (a) Lung cancer w/metastasis to lt. supraclavicular lymph node.
DUE TO, OR AS A CONSEQUENCE OF (b) COPD.
Conditions, if any, which gave rise to immediate cause (c), stating the underlying cause last
DUE TO, OR AS A CONSEQUENCE OF (c) | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | |
| 22a. I certify that (1) (this hospital) attended the deceased from 2/2/82 , 19____, to 2/13/82 , 19____, that (2) (we) lost saw the deceased alive on 2/13/82 and that in my (our) opinion death occurred on the date and hour and from the causes stated above (3) we did not view the body after death. | | | | | | | |
| 22b. SIGNATURE
Chi-Shiang Chen | | | | DEGREE
M.D. | | 22c. DATE SIGNED
2/22/82 | |
| 22b. PHYSICIAN'S NAME (TYPE OR PRINT)
Chi-Shiang Chen, M.D. | | | | 22e. ADDRESS
100 N. Broadway Balto., MD 21231 | | | |
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)
Burial | | 23b. DATE
2/27/82 | | 23c. NAME OF CEMETERY OR CREMATORY
Mt. Auburn Cem. | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
Baltimore MD | |
| 24. FUNERAL DIRECTOR
NAME
Wm. C. March F/H 1101 E. North Ave. | | | | 25a. DATE REC'D. BY REGISTRAR
FEB 23 1982 | | 25b. REGISTRAR'S SIGNATURE
Thomas J. [Signature] | |



Item 3 G 569 7/2/82 GAB

1 - STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 2 0 3 9 4 2

REG. NO.

| | | | | | | | |
|--|--|---|--|--|-----------------------------------|--|--|
| 1. DECEASED NAME
(TYPE OR PRINT)
FIRST MIDDLE LAST
Martha Landon | | | 2a. DATE OF DEATH
MONTH DAY YEAR
FEBRUARY 9, 1982 | | 2b. HOUR
MIN.
09:01p | | |
| 3 SEX
Female | | 4 RACE
NEGRO | | 5. DATE OF BIRTH
MONTH DAY YEAR
NOV 17 1908 | | 6 AGE (IN YEARS (LAST BIRTHDAY))
YRS. MONTHS DAYS
73 | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
MARYLAND | | 7b. CITIZEN OF WHAT COUNTRY?
US of A | | 8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
BALTIMORE CITY | |
| 10 CITY OR TOWN OF DEATH
BALTIMORE | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
JOHNS HOPKINS HOSPITAL | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
RETIRED | | 12b. KIND OF BUSINESS OR INDUSTRY
NURSE | |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)
13a. STATE
MARYLAND | | 13b. COUNTY
BALTIMORE | | 13c. CITY OR TOWN
BALTIMORE | | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 14 FATHER'S NAME
FIRST MIDDLE LAST
JOHN BOLDEN | | 15 MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
LULA REED | | 13e. STREET ADDRESS
2808 REISTERSTOWN ROAD | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
NO | | 16b. SOCIAL SECURITY NO.
(IF YES, GIVE WAR OR DATES)
214 16 5434 | | 17 INFORMANT
ADDRESS
MRS. MARTHA E. PENNINGTON 1916 HARLEM AVE | | | |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART 1. DEATH WAS CAUSED BY:
4149 IMMEDIATE CAUSE (a) Cardiopulmonary Arrest
DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last
(b) Coronary Artery Disease
DUE TO, OR AS A CONSEQUENCE OF
(c) _____ | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 2/1 , 19 82 , to 2/9 , 19 82 , that (I) (we) last saw the deceased alive on 2/9 , 19 82 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | |
| 22b. SIGNATURE
J. Niles MD | | | | DEGREE
ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | 22c. DATE SIGNED
4/9/82 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
JOHN NILES, M.D. | | | | 22e. ADDRESS
JOHNS HOPKINS HOSPITAL | | | |
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)
BURIAL | | 23b. DATE
2/15/82 | | 23c. NAME OF CEMETERY OR CREMATORY
CEDAR HILL CEMETERY | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
BALTIMORE (AA Co.) MD. | |
| 24 FUNERAL DIRECTOR
NAME ADDRESS
LEWIS T. GWYNN 4517 PARK HEIGHTS AVENUE | | | | 25a. DATE REC'D. BY REGISTRAR
FEB 22 1982 | | 25b. REGISTRAR'S SIGNATURE
<i>Thomas Jan...</i> | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. For TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

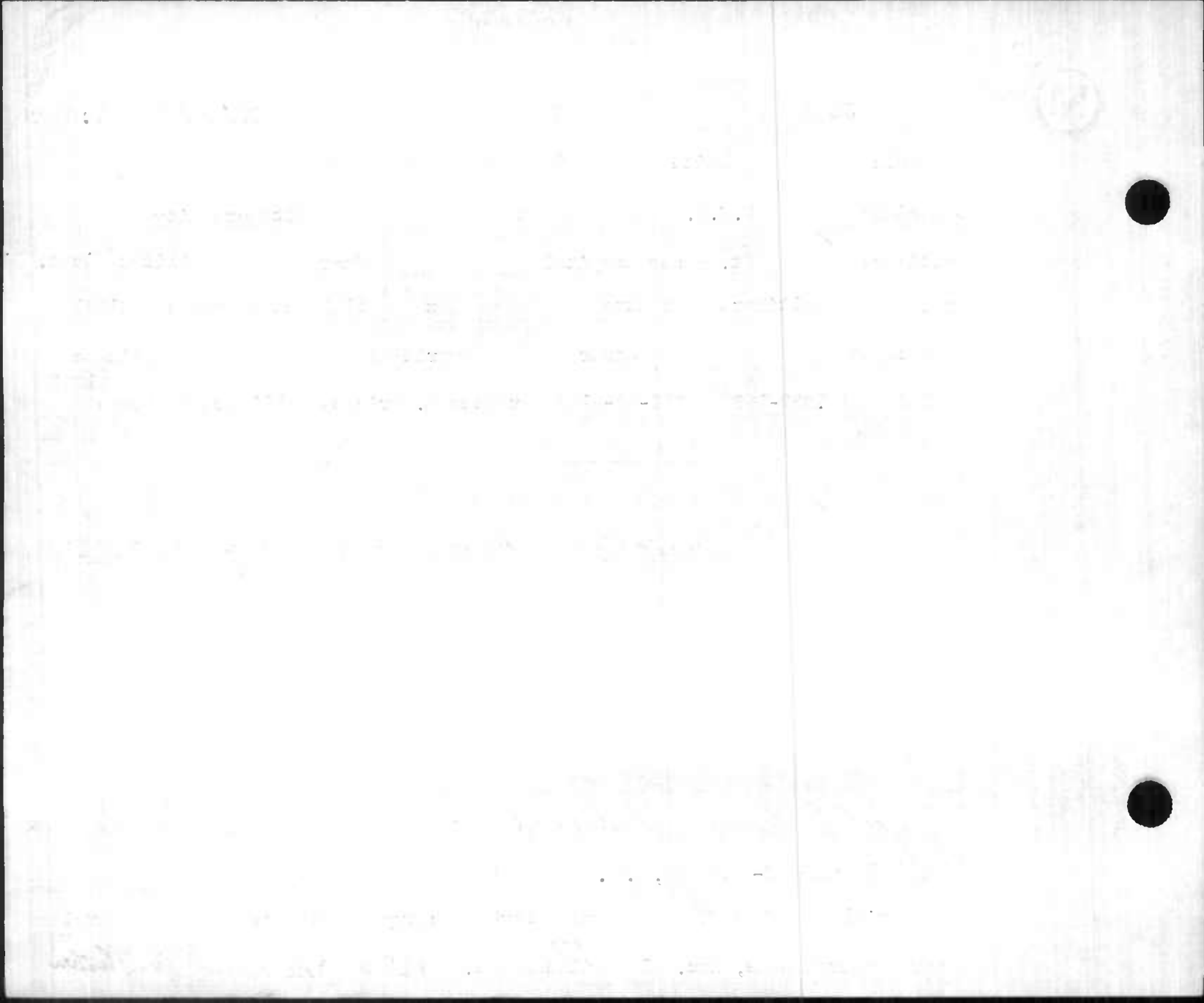
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, should be detached for use as the burial transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 2 0 3 9 4 3

| | | | |
|--|--|--|--|
| 1. FOR STATE REGISTRAR | | REG. NO. | |
| 1. DECEASED NAME (TYPE OR PRINT)
FIRST MIDDLE LAST
JOEL LANDRY | | 2a. DATE OF DEATH MONTH DAY YEAR
02/06/82 | |
| 3 SEX
Male | | 2b. HOUR
1:00PM | |
| 4 RACE
White | | 6. AGE (IN YEARS LAST BIRTHDAY)
76 | |
| 5. DATE OF BIRTH MONTH DAY YEAR
2 4 06 | | IF UNDER 1 YEAR
MONTHS DAYS HOURS MIN. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
Louisiana | | 7b. CITIZEN OF WHAT COUNTRY?
U.S.A. | |
| 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
Baltimore City MD. | |
| 10. CITY OR TOWN OF DEATH
Baltimore | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
St. Agnes Hospital | |
| 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)
Guard | | 12b. KIND OF BUSINESS OR INDUSTRY
Military Dept. of Md. | |
| 13a. STATE
Maryland | | 13b. CITY OR TOWN
Arbutus | |
| 13c. INSIDE CITY LIMITS?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 13d. STREET ADDRESS
5113 Leeds Avenue 21227 | |
| 14. FATHER'S NAME FIRST MIDDLE LAST
Cleopha Landry | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST
Smarlelda Domingue | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)
YES | | 16b. SOCIAL SECURITY NO.
1932-1933 212-09-8144 | |
| 17. INFORMANT
Frances M. Brickey | | ADDRESS
5113 Leeds Avenue 21227 | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY
1629 IMMEDIATE CAUSE (a) Respiratory failure & Sepsis.
DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b) General weakness & Pneumonia
DUE TO, OR AS A CONSEQUENCE OF
(c) metastatic disease CA of Lung | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
10 days.
2 years | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a) | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | |
| 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR
P.M. 19 | |
| 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | 21d. INJURY OCCURRED
WHITE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/> | |
| 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | |
| 22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) lost saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | |
| 22b. SIGNATURE
Rafael Oliver-Vidaud | | DEGREE
M.D. | |
| 22c. DATE SIGNED
2-6-82 | | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
RAFAEL OLIVER-VIDAUD, M.D. | | 22e. ADDRESS
1209 St Agnes LA | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)
Burial | | 23b. DATE
2/9/82 | |
| 23c. NAME OF CEMETERY OR CREMATORY
Loudon Park Cemetery | | 23d. LOCATION CITY OR TOWN COUNTY STATE
Baltimore Maryland | |
| 24. FUNERAL DIRECTOR NAME
Hubbard Funeral Home, Inc. | | ADDRESS
4107 Wilkens Ave. 21229 | |
| 25a. DATE REC'D. BY REGISTRAR
FEB 8 1982 | | 25b. REGISTRAR'S SIGNATURE
Frances Van Thienen | |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, and should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH | | | | 8 2 0 3 9 4 4 | | | |
|---|--|--|--|--|--|--|--|
| FOR
1. STATE REGISTRAR | | | | REG. NO. | | | |
| 1 DECEASED NAME
(TYPE OR PRINT)
FIRST MIDDLE LAST
<i>Lydia Lang</i> | | | | 2a. DATE OF DEATH
MONTH DAY YEAR
<i>2/1/82</i> | | | |
| 3 SEX
<i>F</i> | | 4 RACE
<i>W</i> | | 5. DATE OF BIRTH
MONTH DAY YEAR
<i>9 - 10 - 20</i> | | 6 AGE (IN YEARS (LAST BIRTHDAY))
<i>61</i> YRS | |
| 7a. BIRTHPLACE
(STATE OR FOREIGN COUNTRY)
<i>Md.</i> | | 7b. CITIZEN OF WHAT COUNTRY?
<i>U.S.A.</i> | | 8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9 BALTIMORE CITY OR COUNTY OF DEATH
<i>Baltimore</i> MD. | |
| 10 CITY OR TOWN OF DEATH
<i>Baltimore</i> | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
<i>Hammonds Lane Nursing Home</i> | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
<i>retired-bookkeeper</i> | | 12b. KIND OF BUSINESS OR INDUSTRY | |
| 13a. STATE
<i>Md.</i> | | 13b. COUNTY
<i>Balto.</i> | | 13c. CITY OR TOWN
<i>Balto.</i> | | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 14 FATHER'S NAME
FIRST MIDDLE LAST
<i>John R. Hoffeld</i> | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
<i>Adelaide Lydia Rung</i> | | 13e. STREET ADDRESS
<i>3817 Mt. Pleasant Ave.</i> | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)
<i>no</i> | | 16b. SOCIAL SECURITY NO.
<i>220-09-3504</i> | | 17. INFORMANT
ADDRESS
<i>Pleasant Ave. 3817 Mt.</i> | | | |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <i>Metastasis of Cancer to Brain</i>
<i>1629</i>
DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b) <i>Carcinoma of the Lung</i>
DUE TO, OR AS A CONSEQUENCE OF
(c) | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) | | | | | | | |
| <i>Parkinson's Disease - Hypothyroidism</i> | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. <i>19</i> | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) | | | |
| 21d. INJURY OCCURRED
WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from <i>1-20-82</i> to <i>2-1-82</i> , that (I) (we) lost <i>8-21-19-81</i> above, (I) (we) (did not) view the body after death. | | | | | | | |
| 22b. SIGNATURE
<i>[Signature]</i> | | | | DEGREE
<i>MD</i> | | 22c. DATE SIGNED | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
<i>E-H. Weiss - M.D.</i> | | | | 22e. ADDRESS
<i>606 Hammonds Lane - 21225</i> | | | |
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)
<i>Burial</i> | | 23b. DATE
<i>2/5/82</i> | | 23c. NAME OF CEMETERY OR CREMATORY
<i>Holy Redeemer Cem.</i> | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
<i>Baltimore, MD</i> | |
| 24 FUNERAL DIRECTOR
NAME
<i>Zannino Funeral Home</i> | | | | 25a. DATE REC'D. BY REGISTRAR (TYPE OR PRINT)
<i>FEB 5 1982</i> | | | |
| ADDRESS
<i>263 S. Conkling St.</i> | | | | <i>Frances Jan Kathan</i> | | | |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

Item 6 g566 4/21/82 gj

1- STATE REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

8 2 0 3 9 4 5

| | | | | | | | | | |
|--|--|--|--|---|--|--|--|---|---|
| 1. DECEASED NAME
(TYPE OR PRINT)
EDNA M LANGFORD | | | 2a. DATE OF DEATH
MONTH DAY YEAR
2 21 82 | | | 2b. HOUR
4 P.M. | | | |
| 3. SEX
F | | 4. RACE
W | | 5. DATE OF BIRTH
MONTH DAY YEAR
MAR 25 1903 | | 6. AGE (IN YEARS LAST BIRTHDAY)
79 77 YRS. | | IF UNDER 1 YEAR
MONTHS DAYS
IF UNDER 24 HRS.
HOURS MIN. | |
| 7a. BIRTHPLACE
(STATE OR FOREIGN COUNTRY)
MD | | 7b. CITIZEN OF WHAT COUNTRY?
USA | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
BALTIMORE CITY MD. | | | |
| 10. CITY OR TOWN OF DEATH
BALTIMORE | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
UNION MEMORIAL HOSPITAL | | | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
Housekeeper | | 12b. KIND OF BUSINESS OR INDUSTRY
Church Rectory | |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)
13a. STATE
MD | | | 13b. COUNTY
BALTO | | 13c. CITY OR TOWN
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS
601 Wyanoke Ave | | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
Thomas Murphy | | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
MARY McDonald | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
NO | | 16b. SOCIAL SECURITY NO.
(IF YES, GIVE WAR OR DATES)
212-38-4895 | | 17. INFORMANT
Family Records | | | ADDRESS | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART 1. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) CHF
2041
DUE TO, OR AS A CONSEQUENCE OF
(b) Chronic renal failure
DUE TO, OR AS A CONSEQUENCE OF
(c) ? Chronic lymphocytic leukemia | | | | | | | | | APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATH |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) | | | | | | | | | |
| 19a. DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED
IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER NOTIFY MEDICAL EXAMINER) | | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | |
| 21d. INJURY OCCURRED
WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 2/17, 19 82, to 2/21, 19 82, that (I) (we) lost
saw the deceased alive on 2/21, 19 82, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated
above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | |
| 22b. SIGNATURE
Bryan H. Kahn | | | DEGREE
M.D. | | | ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> | | 22c. DATE SIGNED
2/21/82 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
BRIAN H. KAHN | | | 22e. ADDRESS
UNION MEMORIAL HOSPITAL | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)
BURIAL | | | 23b. DATE
2/24/82 | | 23c. NAME OF CEMETERY OR CREMATORY
PARKWOOD | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
BALTO MD | | |
| 24. FUNERAL DIRECTOR
NAME
EVANS FUNERAL Chapel 8800S Hanford Rd | | | | | 25a. DATE REC'D. BY REGISTRAR
MAR 2 1982 | | 25b. REGISTRAR'S SIGNATURE
Frances Jean Nathan | | |

SECRET

SECRET

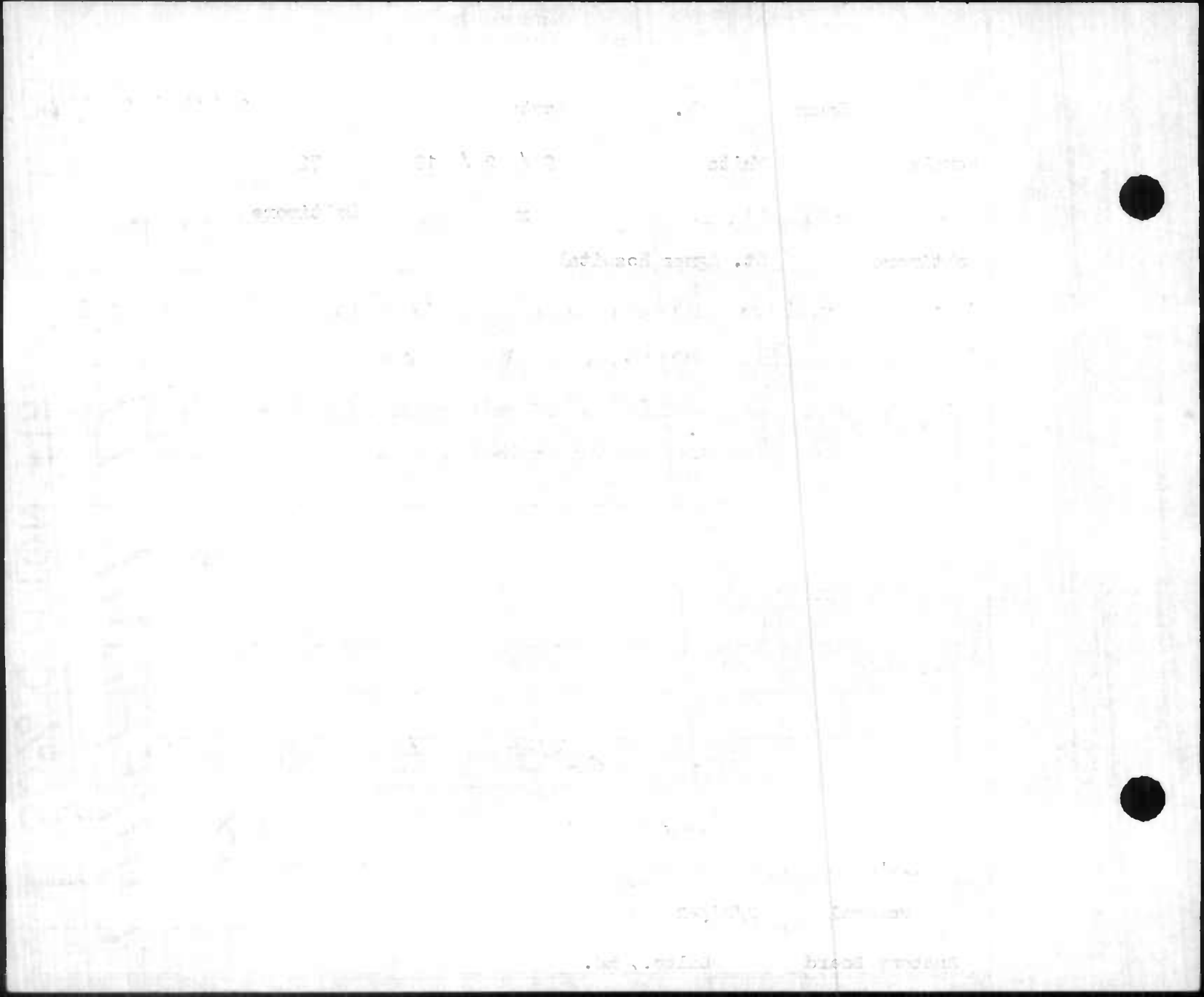
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be contacted.1. FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 2 0 3 9 4 6

REG. NO.

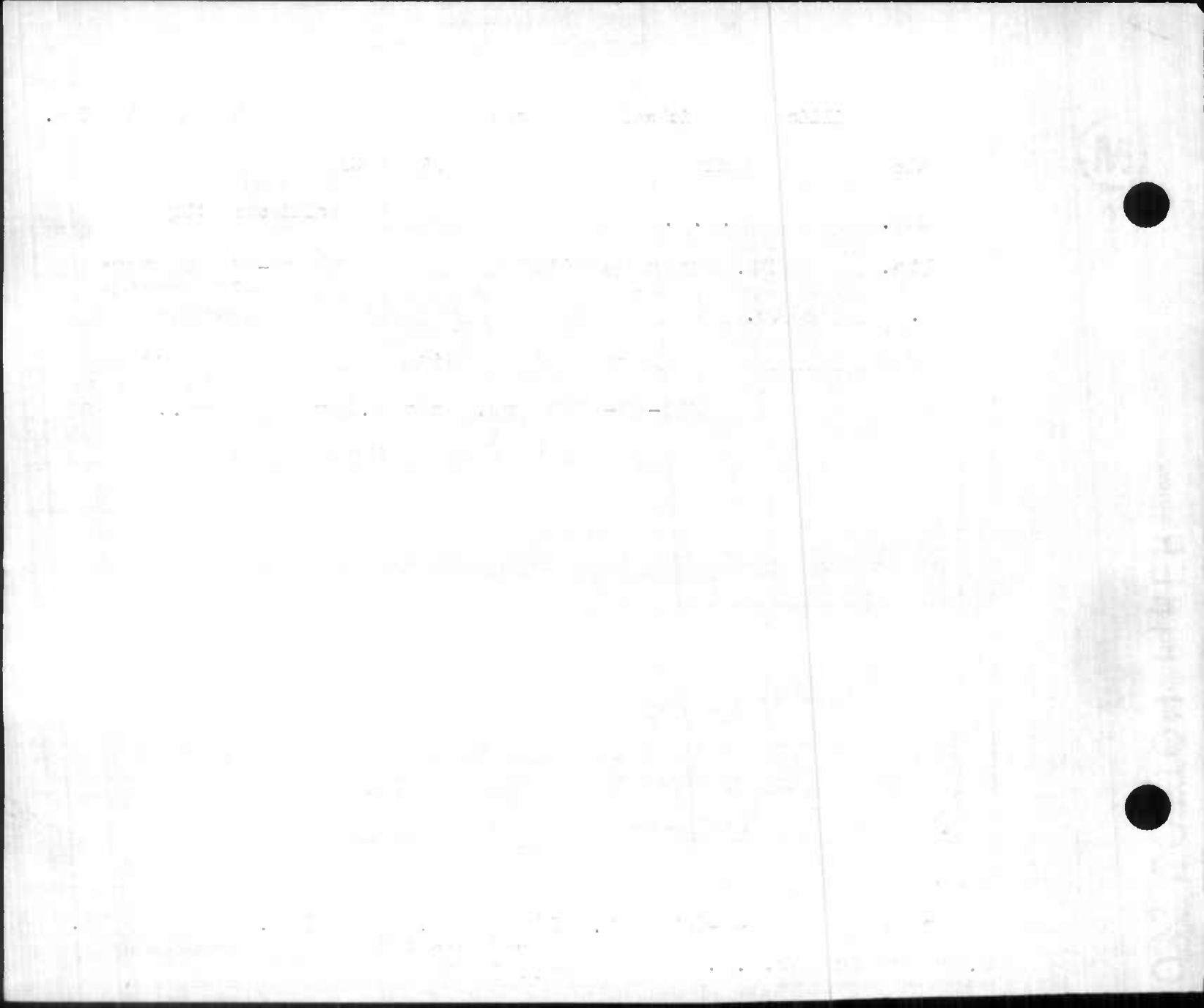
| | | | | | |
|--|--|---|---|--|--|
| 1. DECEASED NAME
(TYPE OR PRINT)
FIRST MIDDLE LAST
Laura V. Lantz | | | 2a. DATE OF DEATH
MONTH DAY YEAR
2 / 24 / 82 | | 2b. HOUR
7 PM |
| 3. SEX
Female | 4. RACE
White | 5. DATE OF BIRTH
MONTH DAY YEAR
2 / 2 / 10 | | 6. AGE (IN YEARS LAST BIRTHDAY)
72 YRS. | IF UNDER 1 YEAR
MONTHS DAYS HOURS MIN. |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
Baltimore | 7b. CITIZEN OF WHAT COUNTRY?
U.S. | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
Baltimore City MD. | |
| 10. CITY OR TOWN OF DEATH
Baltimore | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
St. Agnes Hospital | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE) | | 12b. KIND OF BUSINESS OR INDUSTRY |
| 13a. STATE
md. | 13b. COUNTY
Balto | 13c. CITY OR TOWN
Arbutus | 13d. INSIDE CITY LIMITS?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | 13e. STREET ADDRESS
4801 Greenville Sq. | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
Darius P. Jackson | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
Nellie P. | | 16. SOCIAL SECURITY NO.
220-07-0356 | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
NO | | 17. INFORMANT
Patricia Jackson - above | | ADDRESS
same as above | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART 1. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Carcinoma Lungs
1629
DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b) _____
DUE TO, OR AS A CONSEQUENCE OF
(c) _____ | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)
Carcinoma Breast. C.O. P.D. | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input type="checkbox"/> | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK AT WORK | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | |
| 22a. I certify that (I) (this hospital) attended the deceased from 2/24 , 19 82 , to 2/24 , 19 82 , that (I) (we) lost
saw the deceased alive on 2/24 , 19 82 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated
above, (I) (we) (did) (did not) view the body after death. | | | | | |
| 22b. SIGNATURE
W. Bradley Pitalo | | DEGREE
MD | | 22c. DATE SIGNED
2/24/82 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
W. BRADLEY PITALO | | 22e. ADDRESS
ST. AGNES HOSPITAL | | | |
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)
Removal | | 23b. DATE
2/24/82 | | 23c. NAME OF CEMETERY OR CREMATORY | |
| 24. FUNERAL DIRECTOR
NAME
Anatomy Board | | ADDRESS
Balto., Md. | | 25a. DATE REC'D. BY REGISTRAR
MAR 2 1982 | |
| | | | | 25b. REGISTRAR'S SIGNATURE
<i>[Signature]</i> | |



STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

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|--|--|---|--|
| 1 - FOR
STATE
REGISTRAR | | REG. NO. | |
| 1. DECEASED NAME
(TYPE OR PRINT) | | 2a. DATE OF DEATH | |
| FIRST MIDDLE LAST
William Michael Lark | | MONTH DAY YEAR
2 05 82 | |
| 3. SEX
Male | | 7b. HOUR
7 p.m. | |
| 4. RACE
White | | 5. DATE OF BIRTH | |
| | | MONTH DAY YEAR
8 9 56 | |
| 6a. BIRTHPLACE
(STATE OR FOREIGN
COUNTRY)
Md. | | 6. AGE (IN YEARS LAST BIRTHDAY)
25 | |
| 7b. CITIZEN OF WHAT COUNTRY?
U.S.A. | | IF UNDER 1 YEAR
MONTHS DAYS HOURS MIN.
YRS. | |
| 10. CITY OR TOWN OF DEATH
Balto. | | 9. BALTIMORE CITY OR COUNTY OF DEATH
Baltimore City MD | |
| 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
St. Agnes Hospital | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
Clerk-Giant Store | |
| 13a. STATE
Md. | | 13b. STREET ADDRESS
3412 Hopkins Avenue | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
Toy Lark | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
Edith Riley | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
No | | 16b. SOCIAL SECURITY NO.
213-68-5746 | |
| 17. INFORMANT
Mrs. Sandy S. Lark | | ADDRESS
3412 Hopkins Ave., 21227 | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))
PART 1. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>Ruptured Berry Aneurysm</u>
4300
DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b) _____
DUE TO, OR AS A CONSEQUENCE OF
(c) _____
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) _____ | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | |
| 20a. AUTOPSY?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | |
| 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | 21d. INJURY OCCURRED
21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | |
| 21f. INJURY OCCURRED
WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21g. LOCATION
STREET CITY OR TOWN COUNTY STATE | |
| 22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) lost
saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated
above, (I) (we) (did) (did not) view the body after death. | | | |
| 22b. SIGNATURE
Bert F. Morton | | DEGREE
M.D. | |
| 22c. PHYSICIAN'S NAME (TYPE OR PRINT)
Bert F. Morton | | 22d. ADDRESS
3512 Frederick Ave., 21227 | |
| 22e. DATE SIGNED
Feb 10 1982 | | 22f. PHYSICIAN'S NAME (TYPE OR PRINT)
G. Truman Schwab, P.A. | |
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)
Burial | | 23b. DATE
2-9-82 | |
| 23c. NAME OF CEMETERY OR CREMATORY
Mt. Olivet Cem. | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
Balto. Md. | |
| 24. FUNERAL DIRECTOR
NAME
G. Truman Schwab, P.A. | | | |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the funeral director's office death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

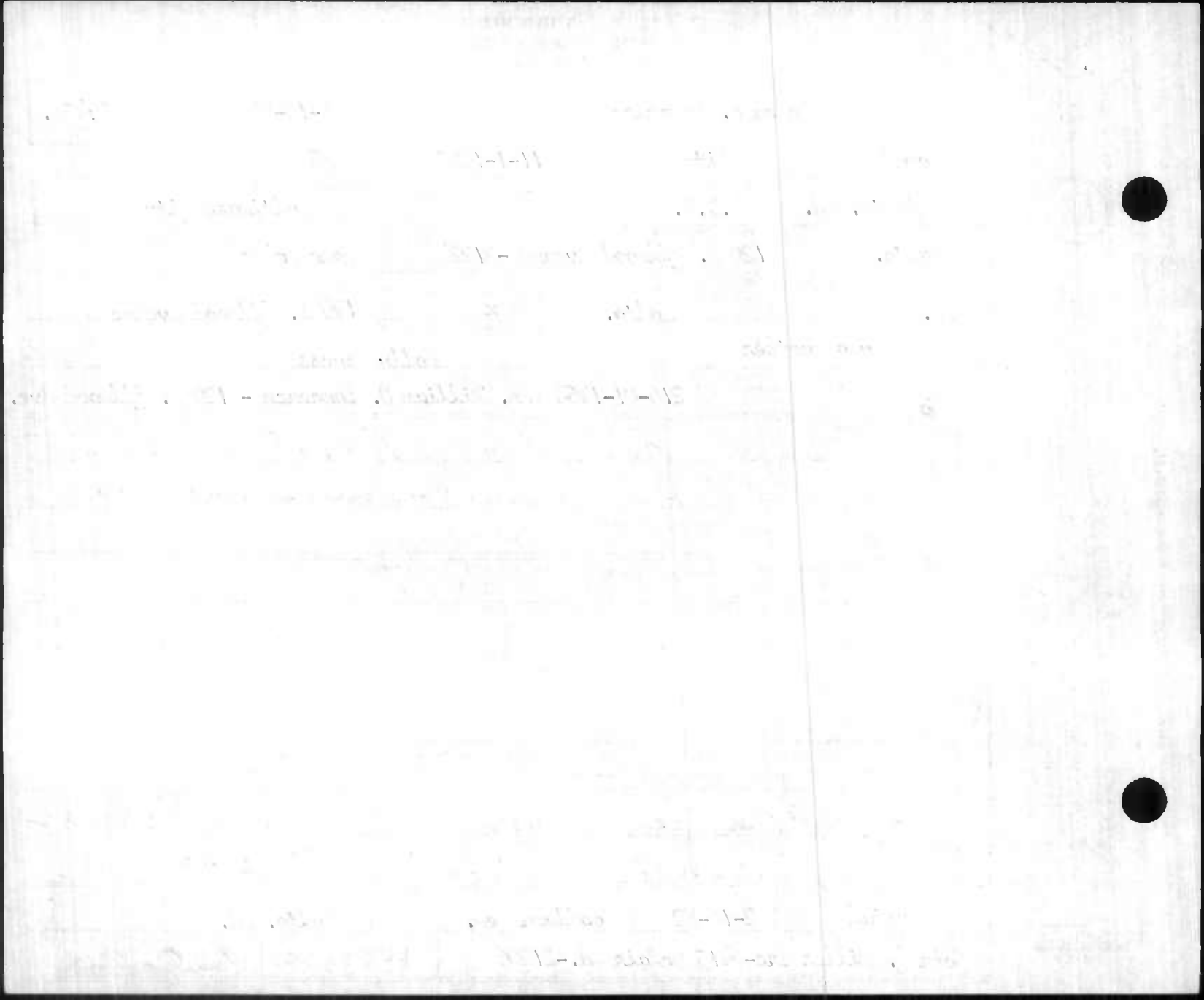
STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 2 0 3 9 4 8

1 - FOR
STATE
REGISTRAR

REG. NO.

| | | | | | | | | | |
|--|--|--|---|---|---|--|--|---|--|
| 1. DECEASED NAME
(TYPE OR PRINT)
FIRST MIDDLE LAST
<i>Helen D. Lawrence</i> | | | 2a. DATE OF DEATH
MONTH DAY YEAR
<i>2-12-82</i> | | 2b. HOUR
<i>2:45 P.M.</i> | | | | |
| 3. SEX
<i>Female</i> | | 4. RACE
<i>White</i> | | 5. DATE OF BIRTH
MONTH DAY YEAR
<i>11-1-1899</i> | | 6. AGE (IN YEARS (LAST BIRTHDAY))
<i>82</i>
YRS. MONTHS DAYS
IF UNDER 1 YEAR IF UNDER 24 HRS. | | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
<i>Balto. Md.</i> | | 7b. CITIZEN OF WHAT COUNTRY?
<i>U.S.A.</i> | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
<i>Baltimore City</i> MD. | | | |
| 10. CITY OR TOWN OF DEATH
<i>Balto.</i> | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(NAME AND STREET ADDRESS)
<i>120 S. Ellwood Avenue - 21224</i> | | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
<i>Home Maker</i> | | 12b. KIND OF BUSINESS OR INDUSTRY | | |
| 13a. STATE
<i>Md.</i> | | 13b. COUNTY | | 13c. CITY OR TOWN
<i>Balto.</i> | | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS
<i>120 S. Ellwood Avenue</i> | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
<i>Hugo Huether</i> | | | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
<i>Molly Pruess</i> | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
<i>No</i> | | 16b. SOCIAL SECURITY NO.
<i>216-01-1468</i> | | 17. INFORMANT ADDRESS
<i>MR. William D. Lawrence - 120 S. Ellwood Ave.</i> | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART 1. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <i>MYOCARDIAL INFARCT</i>
<i>4100</i>
DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b) <i>HYPERTENSIVE CARDIOVASCULAR DISEASE</i>
DUE TO, OR AS A CONSEQUENCE OF
(c)
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
<i>2 hours</i>
<i>years</i> | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a): | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | | | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> AT WORK
AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) lost
saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated
above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | |
| 22b. SIGNATURE
<i>Harry C Bowie</i> | | | | DEGREE
<i>MD.</i> | | 22c. DATE SIGNED
<i>2/17/82</i> | | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
<i>Harry C Bowie</i> | | | | 22e. ADDRESS
<i>926 St Paul St. Baltimore MD 21202</i> | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)
<i>Burial</i> | | 23b. DATE
<i>2-16-82</i> | | 23c. NAME OF CEMETERY OR CREMATORY
<i>Woodlawn Cem.</i> | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
<i>Balto. Md.</i> | | | |
| 24. FUNERAL DIRECTOR
NAME ADDRESS
<i>John C. Miller Inc 6415 Belair Rd. - 21206</i> | | | | 25a. DATE REC'D. BY REGISTRAR
<i>FEB 16 1982</i> | | 25b. REGISTRAR'S SIGNATURE
<i>James J. [Signature]</i> | | | |

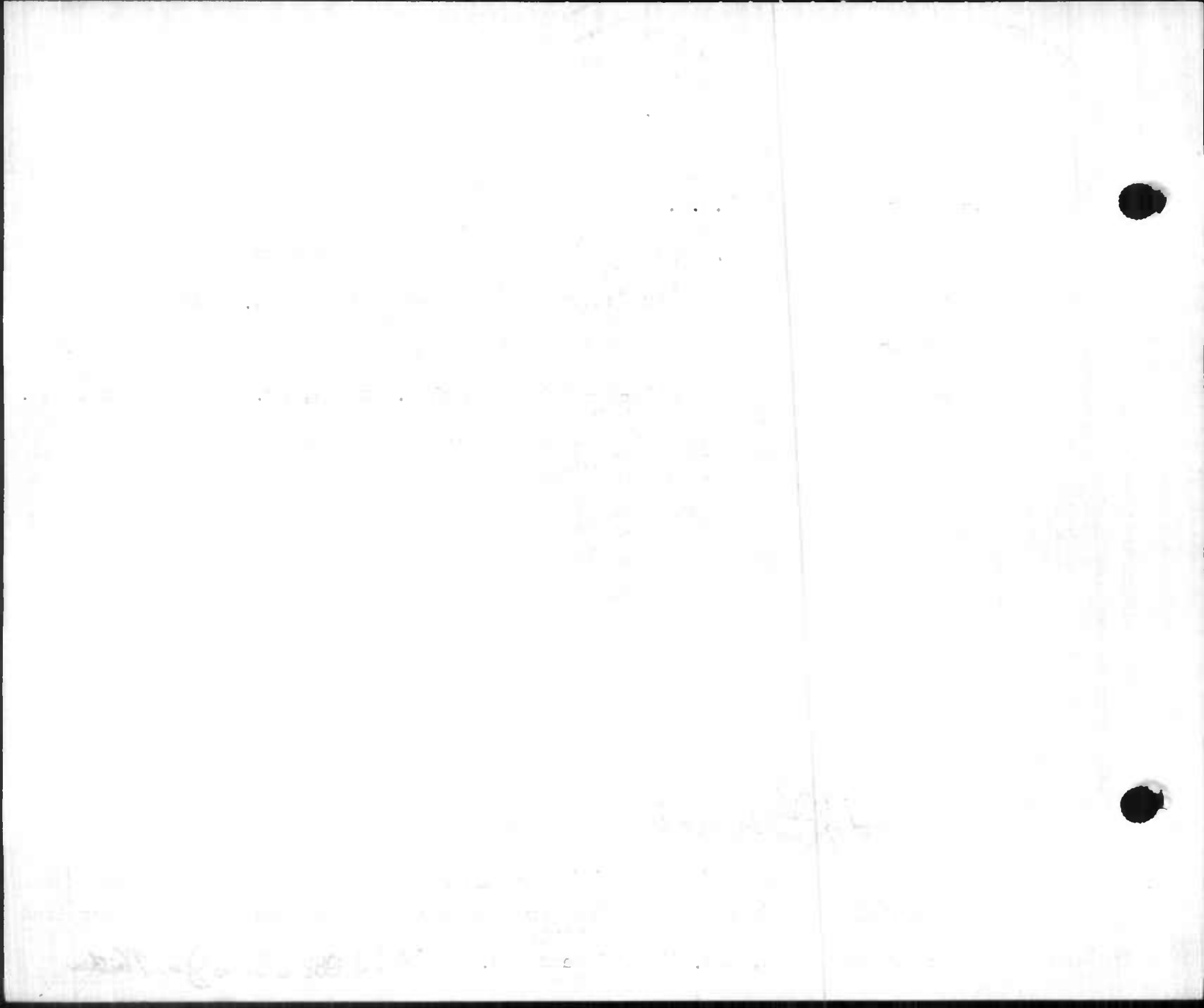


TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE FORMS 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM-3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 24 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP

DHMH - 17
(VR A15 ME (5))
15M 2/80

| STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH | | | | | | | | | | REG. NO. 2 0 3 9 4 9 | |
|--|--|------------------|--|---|--|---|--|---|---------------|---|--|
| 1. FOR STATE REGISTRAR | | | | | | | | | | | |
| 1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST
Gladys M. Lawson | | | | | | | 2a. DATE KNOWN OF DEATH ESTI- MATED <input checked="" type="checkbox"/> MONTH DAY YEAR
2 17 19 82 | | 2b. HOUR
M | | |
| 3. SEX
female | | 4. RACE
white | | 5. DATE OF BIRTH MONTH DAY YEAR
10 03 07 | | 6. AGE (IN YEARS) (LAST BIRTHDAY) MONTHS DAYS HOURS MIN.
74 YRS. | | 7c. DATE PRONOUNCED DEAD
2 17 19 82 | | 7d. HOUR
7:31A | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
Pennsylvania | | | | 7b. CITIZEN OF WHAT COUNTRY?
U.S.A. | | | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
Baltimore City MD. | |
| 10. CITY OR TOWN OF DEATH
Baltimore | | | | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
St. Agnes Hospital | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)
Homemaker | | 12b. KIND OF BUSINESS OR INDUSTRY | |
| USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) | | | | | | | | | | | |
| 13a. STATE
Florida | | 13b. COUNTY | | 13c. CITY OR TOWN
Bradenton | | 13d. INSIDE CITY LIMITS?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 13e. STREET ADDRESS
2102 21 st. Avenue | | 33505 | |
| 14. FATHER'S NAME FIRST MIDDLE LAST
Elsworth Cass | | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST
Emma Thornton | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)
NO | | | | 16b. SOCIAL SECURITY NO.
215-30-1202 | | 17. INFORMANT ADDRESS
Earl S. Crouse, Jr. 821 Mill Creek Rd. | | | | 21012 | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I DEATH WAS CAUSED BY:
4292 IMMEDIATE CAUSE (a) Arteriosclerotic cardiovascular disease
Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.
(b) DUE TO, OR AS A CONSEQUENCE OF
(c) DUE TO, OR AS A CONSEQUENCE OF | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a). | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | | | | | | 20. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH | | | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) | | | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/> | | | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) | | 21f. LOCATION CITY OR TOWN COUNTY STATE | | | | | |
| 22a. I certify that I took charge of the remains described above, held on death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion | | | | | | | | | | | |
| ACTUAL SIGNATURE <i>H R Guard</i> | | | | TITLE (SPECIFY)
Assistant | | | | DATE SIGNED 2/17/82 | | | |
| EXAMINER'S NAME (TYPE OR PRINT)
Hormez R. Guard, M.D. | | | | ADDRESS
111 Penn Street, Balto, MD 21201 | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)
Burial | | | | 23b. DATE
2/20/82 | | 23c. NAME OF CEMETERY OR CREMATORY
Loudon Park Cemetery | | | | 23d. LOCATION CITY OR TOWN COUNTY STATE
Baltimore Maryland | |
| 24. FUNERAL DIRECTOR NAME
Hubbard Funeral Home, Inc. 4107 Wilkens Ave. | | | | | | 25a. DATE REC'D. BY REGISTRAR
FEB 19 1982 | | 25b. REGISTRAR'S SIGNATURE
<i>Charles J. Norton</i> | | | |



STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 2 0 3 9 5 0

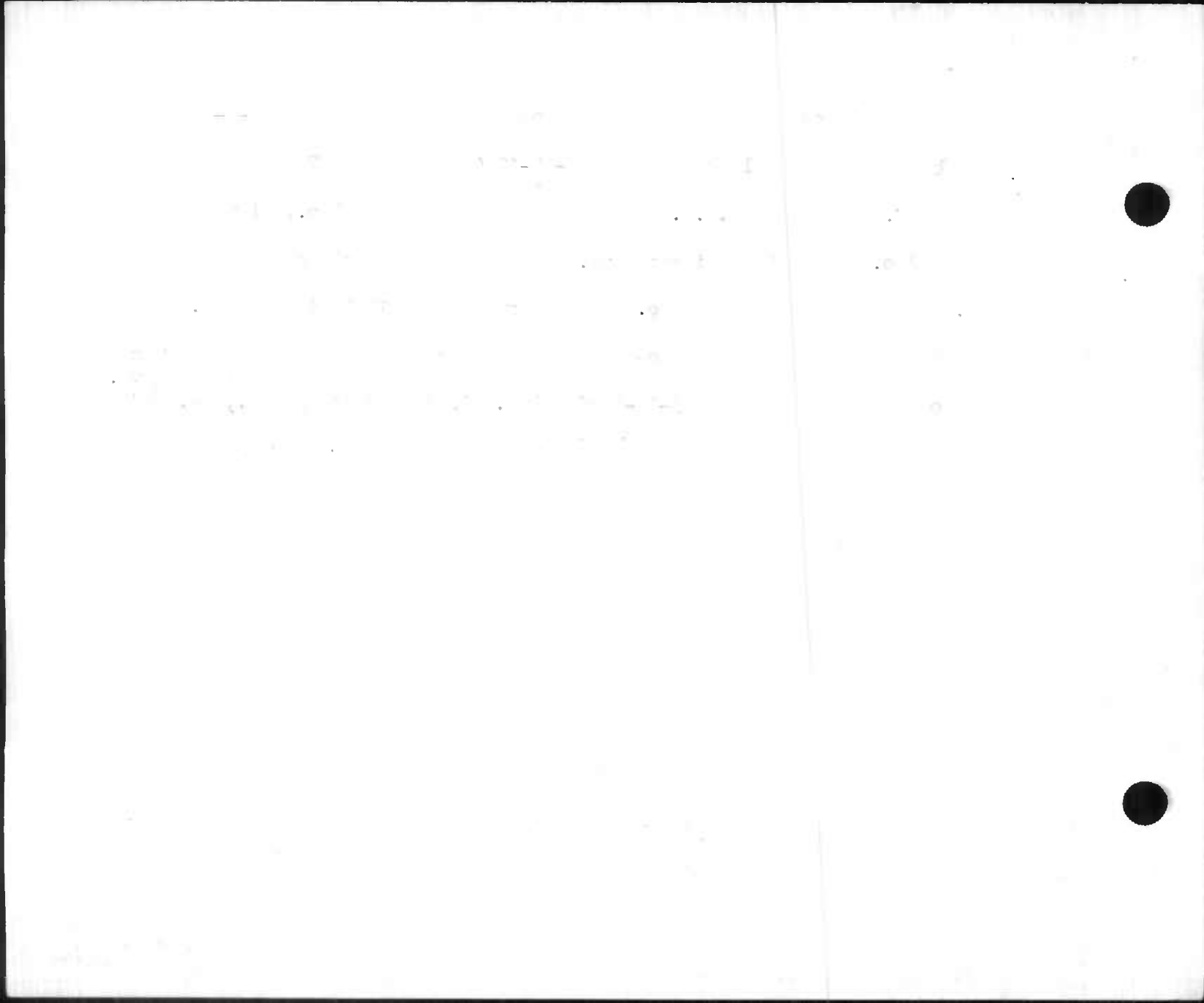
REG. NO.

1. FOR
STATE
REGISTRAR

| | | | | | | | | | | | |
|---|--|--|--|---|--|---|---|---|--|--|--|
| 1. DECEASED NAME
(TYPE OR PRINT)
MILTON LAYTON | | | 2a. DATE OF DEATH MONTH DAY YEAR
2-2-82 | | | 2b. HOUR
10:30 AM | | | | | |
| 3. SEX
Male | | 4. RACE
Black | | 5. DATE OF BIRTH
MONTH DAY YEAR
5-20-1910 | | 6. AGE (IN YEARS LAST BIRTHDAY)
71 YRS. | | 7. IF UNDER 1 YEAR
MONTHS DAYS | | 7. IF UNDER 24 HRS
HOURS MIN. | |
| 7b. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
Md. | | 7c. CITIZEN OF WHAT COUNTRY?
U.S.A. | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
Balto., City MD. | | | | | |
| 10. CITY OR TOWN OF DEATH
Balto. | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
1340 Winston Ave. | | | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
Steel Worker | | | 12b. KIND OF BUSINESS OR INDUSTRY | | |
| 13a. STATE
Md. | | 13b. COUNTY | | 13c. CITY OR TOWN
Balto. | | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS
1340 Winston Ave. | | | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
Henry Layton | | | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
Theresa Simms | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
No | | 16b. SOCIAL SECURITY NO.
(IF YES, GIVE WAR OR DATES)
213-12-0865 A | | 17. INFORMANT
ADDRESS
1340 Winston Ave.
Mrs. Lillian Layton Balto., Md. 21239 | | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY
IMMEDIATE CAUSE (a) 4379 CONGESTIVE HEART FAILURE
DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last
(b) CEREBROVASCULAR DISEASE AND 10YR
(c) DIABETES 10YR | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a). | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | | | | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/> | | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from Jan 1978, 19, to Jan 1982, that (I) (we) last saw the deceased alive on Dec 19, 82, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) did not view the body after death. | | | | | | | | | | | |
| 22b. SIGNATURE
Edward James Britt DEGREE
ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | | | | | | | 22c. DATE SIGNED
2/3/82 | | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
EDWARD JAMES BRITT | | | | | | 22e. ADDRESS
GOOD SAMARITAN HOSPITAL BALTO 21239 | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)
Burial | | | 23b. DATE
2/6/82 | | 23c. NAME OF CEMETERY OR CREMATORY
Arbutus Mem Pk | | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
Balto. Md | | | |
| 24. FUNERAL DIRECTOR
NAME ADDRESS
Chatman F/H 1701 McCulloch St | | | | | | 25a. DATE REC'D. BY REGISTRAR
FEB 4 1982 | | 25b. REGISTRAR'S SIGNATURE
Charles Jan Nathan | | | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be filed within 72 hours after death.

BP
DHMH-16 20M
(VRA 15, 4) 7/78



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Pages 1 and 2 should be filed within 72 hours of death. The medical examiner must be notified of a death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours of death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of a death.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 2 0 3 9 5 1

FOR
1- STATE
REGISTRAR

REG. NO.

| | | | | | |
|---|-------------------------|---|--|---|--|
| 1. DECEASED NAME
(TYPE OR PRINT)
Jack L. LAZAR | | 2a. DATE OF DEATH
2-28-82 | | 2b. HOUR
5:49P | |
| 3. SEX
MALE | 4. RACE
WHITE | 5. DATE OF BIRTH
MONTH APR. DAY 23, YEAR 1932 | | 6. AGE (IN YEARS LAST BIRTHDAY)
49 | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
NEW YORK | | 7b. CITIZEN OF WHAT COUNTRY?
USA | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | |
| 10. CITY OR TOWN OF DEATH
BALTIMORE | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
John Hopkins Hospital | | 9. BALTIMORE CITY OR COUNTY OF DEATH
Baltimore City MD | |
| 12a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)
13a. STATE
MARYLAND | | 13b. COUNTY
BALTO. | | 13c. CITY OR TOWN
BALTIMORE | |
| 14. FATHER'S NAME
FIRST HERMAN MIDDLE LAZAR | | 15. MOTHER'S MAIDEN NAME
FIRST MAY MIDDLE FINKELSTEIN | | 13d. INSIDE CITY LIMITS?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
YES | | 16b. SOCIAL SECURITY NO.
101-26-3326 | | 17. INFORMANT
MRS. MYRNA LAZAR | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART 1. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Respiratory Failure
DUE TO, OR AS A CONSEQUENCE OF
(b) interstitial lung disease
DUE TO, OR AS A CONSEQUENCE OF
(c) _____ | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (c)
disseminated intravascular coagulation, acute renal failure | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | |
| 22a. I certify that (1) (this hospital) attended the deceased from 2/27 , 19 82 , to 2/28 , 19 82 , that (1) (we) lost
saw the deceased alive on 2/28 , 19 82 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated
above (1) (we) (did) (did not) view the body after death. | | | | | |
| 22b. SIGNATURE
Pam Sholar, M.D. | | DEGREE | | 22c. DATE SIGNED
2/28/82 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
Pam Sholar, M.D. | | 22e. ADDRESS
The Johns Hopkins Hospital | | | |
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)
BURIAL | | 23b. DATE
MAR. 2, 1982 | | 23c. NAME OF CEMETERY OR CREMATORY
LIBERTY PARK | |
| 24. FUNERAL DIRECTOR
NAME
SOL LEVINSON & BROS., INC. | | 25a. DATE REC'D. BY REGISTRAR
MAR 4 1982 | | 25b. REGISTRAR'S SIGNATURE
James J. Nathan | |
| 6010 REISTERSTOWN RD. BALTO., MD 21215 | | 23d. LOCATION
RANDALLSTOWN BALTO. MD | | | |

17500 15

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 2 0 3 9 5 2

1 - FOR
STATE
REGISTRAR

REG. NO.

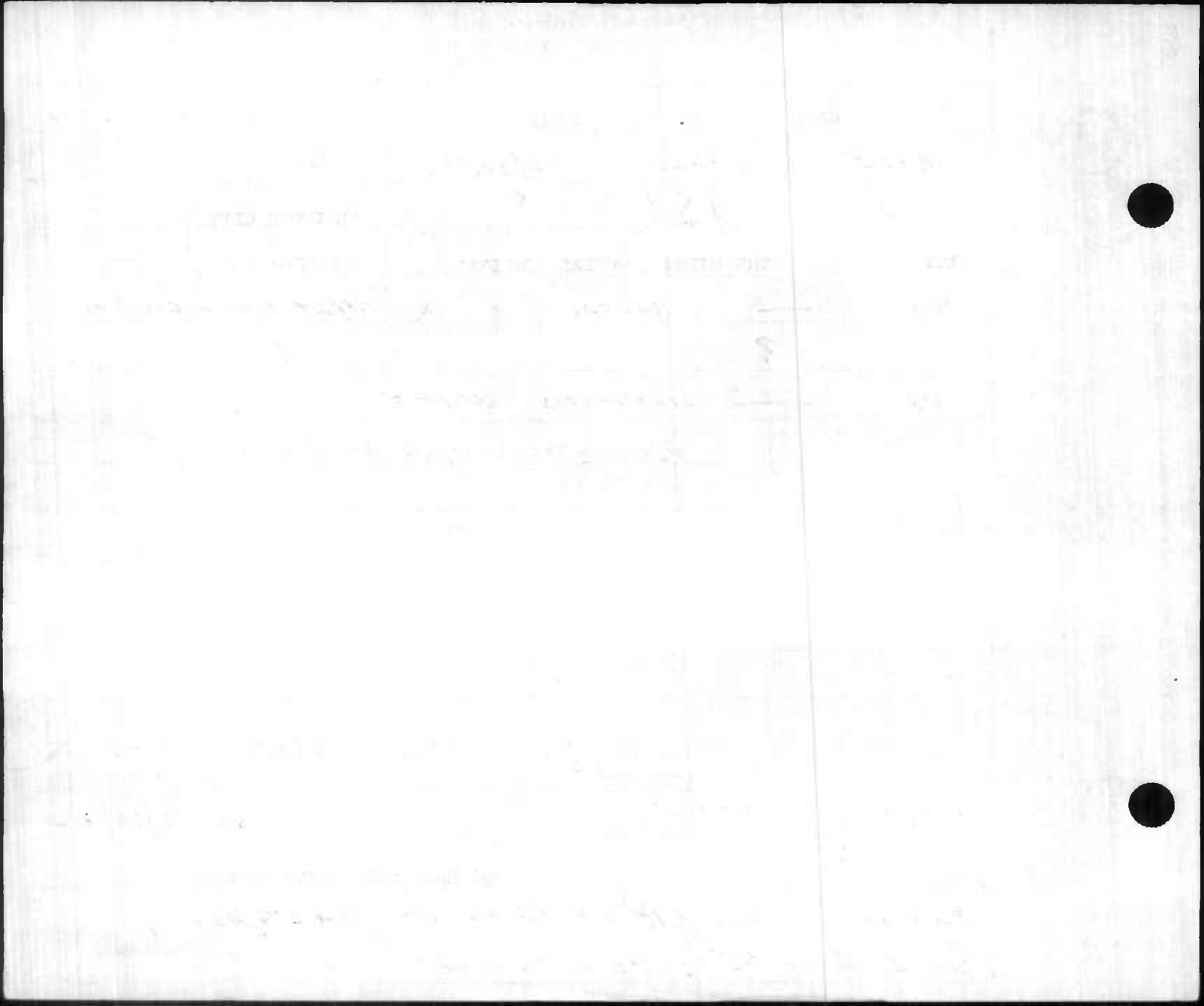
| | | | | | | | |
|---|---|---|---|--|--|---|--|
| 1. DECEASED NAME
(TYPE OR PRINT)
EARL E. LEACH | | | 2a. DATE OF DEATH
MONTH DAY YEAR
2/25/82 | | | 2b. HOUR
2:32 A.M. | |
| 3. SEX
MALE | 4. RACE
CAUC. | 5. DATE OF BIRTH
MONTH DAY YEAR
12/20/05 | | 6. AGE (IN YEARS LAST BIRTHDAY)
76 | | IF UNDER 1 YEAR
MONTHS DAYS
76 | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
MD. | 7b. CITIZEN OF WHAT COUNTRY?
USA | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
BALTIMORE CITY MD. | | | |
| 10. CITY OR TOWN OF DEATH
CITY | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
THE UNION MEMORIAL HOSPITAL | | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
RETIRED | | 12b. KIND OF BUSINESS OR INDUSTRY
— | |
| 13a. STATE
MD. | | 13b. COUNTY
— | | 13c. CITY OR TOWN
BALTO. | | 13d. INSIDE CITY LIMITS?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
? ? ? | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
? ? ? | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
NO | | 16b. SOCIAL SECURITY NO.
212-01-4903 | | 17. INFORMANT
ADDRESS
WIFE | | | |

| | | |
|---|--|---|
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART 1. DEATH WAS CAUSED BY:
1850
IMMEDIATE CAUSE (a) METASTATIC CANCER OF PROSTATE
DUE TO, OR AS A CONSEQUENCE OF
(b) —
DUE TO, OR AS A CONSEQUENCE OF
(c) — | | APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATH |
|---|--|---|

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)

| | | | | | | | |
|--|--|--|--|--|--|---|--|
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED
IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
— P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 2/10 , 19 82 , to 2/25 , 19 82 , that (I) (we) last saw the deceased alive on 2/25 , 19 82 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | |
| 22b. SIGNATURE
Ramsey MD | | | | DEGREE
— | | 22c. DATE SIGNED
2/25/82 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) | | | | 22e. ADDRESS
201 EAST UNIVERSITY PARKWAY | | | |

| | | | | | | | |
|---|--|-----------------------------|--|---|--|---|--|
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)
BURIAL | | 23b. DATE
2/27/82 | | 23c. NAME OF CEMETERY OR CREMATORY
LORRAINE PK. | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
BALTO. MD. | |
| 24. FUNERAL DIRECTOR
NAME
Paul E. Chomov | | | | ADDRESS
3617 CHESTNUT AVE. | | 25a. DATE REC'D. BY REGISTRAR
MAR 1 1982 | |



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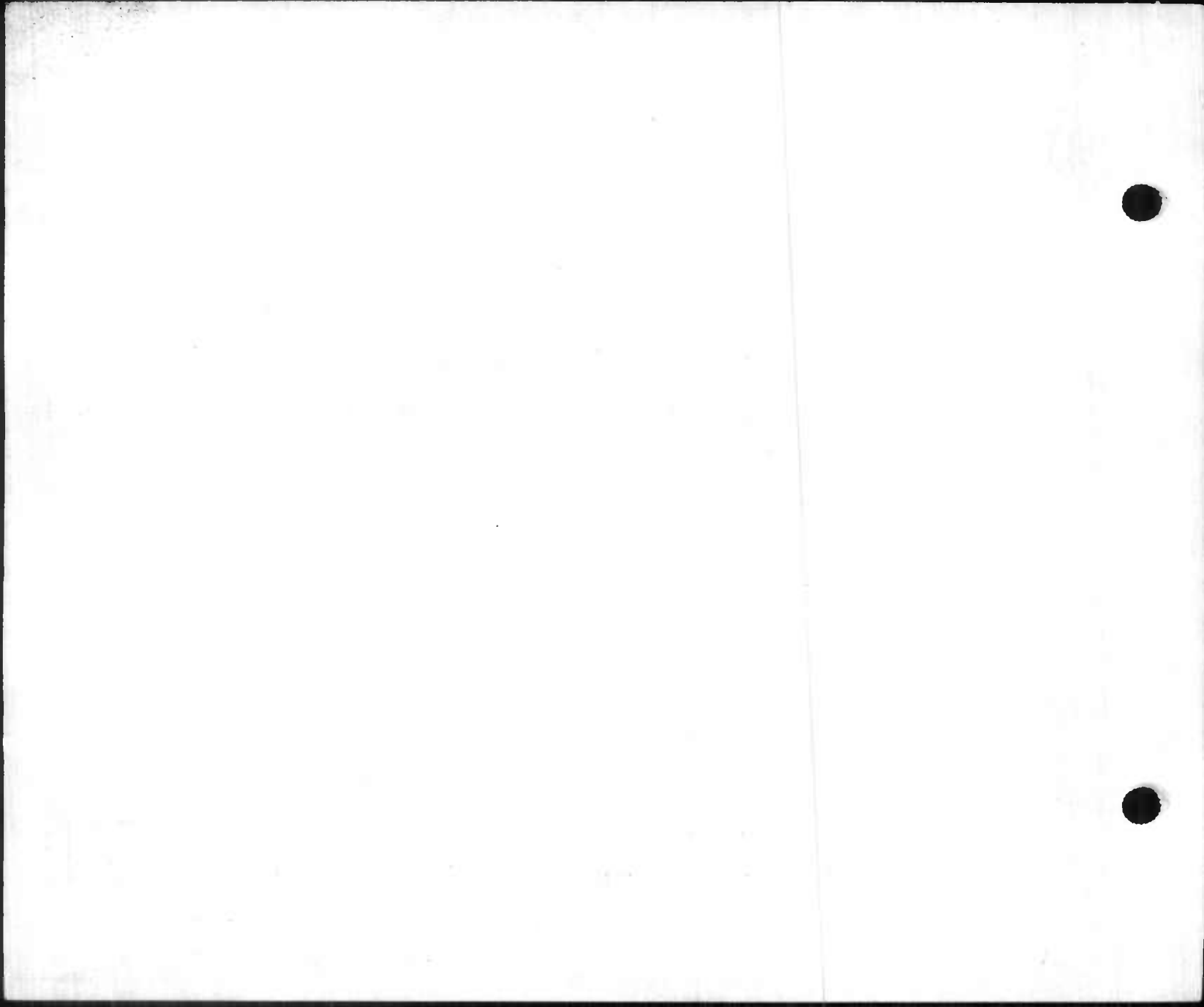
2240

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, THE MEDICAL EXAMINER SHOULD EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. GIVE PAGE 4 TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR OFFICE. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED. WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | | | | | |
|--|--|---|--|--|--|--|--|--|--|---|--|
| 1- FOR STATE REGISTRAR | | 2- DATE KNOWN OF DEATH | | 3- MONTH | | 4- DAY | | 5- YEAR | | 6- HOUR | |
| 1. DECEASED NAME (TYPE OR PRINT) | | FIRST | | MIDDLE | | LAST | | 2. DATE KNOWN OF DEATH | | 3. MONTH | |
| DUBOIS | | L. | | LEAZER | | 2. DATE KNOWN OF DEATH | | 3. MONTH | | 4. DAY | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) | | 7b. CITIZEN OF WHAT COUNTRY? | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH | | 10. CITY OR TOWN OF DEATH | | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) | |
| Md. | | USA | | | | Baltimore City | | Baltimore | | 4615 Manordene Rd. | |
| 12a. USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) | | 12b. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | | 12c. KIND OF BUSINESS OR INDUSTRY | | 13a. STATE | | 13b. COUNTY | | 13c. CITY OR TOWN | |
| Md. | | | | Balto. | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS | | 4615 Manordene Rd. | |
| 14. FATHER'S NAME (FIRST MIDDLE LAST) | | 15. MOTHER'S MAIDEN NAME (FIRST MIDDLE LAST) | | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) | | 16b. SOCIAL SECURITY NO. | | 17. INFORMANT | | ADDRESS | |
| Marshall | | Annette Winley | | N/A | | N/A | | Addie Wiggins | | 4615 Manordene Rd. | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>Sudden Infant Death Syndrome</u>
7980
Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.
(b) _____
(c) _____
DUE TO, OR AS A CONSEQUENCE OF
DUE TO, OR AS A CONSEQUENCE OF
DUE TO, OR AS A CONSEQUENCE OF | | | | | | | | | | | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a). | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | | 20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) | | 21f. LOCATION CITY OR TOWN COUNTY STATE | | 22a. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> . | | 22b. TITLE (SPECIFY) Assistant MEDICAL EXAMINER | | DATE SIGNED 2-25-82 | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) | | 23b. DATE | | 23c. NAME OF CEMETERY OR CREMATORY | | 23d. LOCATION CITY OR TOWN COUNTY STATE | | 24. FUNERAL DIRECTOR NAME ADDRESS | | 25a. DATE REC'D. BY REGISTRAR | |
| Burial | | 3/1/82 | | Cedar Hill Cem. | | Anne Arundel Co., Md. | | Wm C March F/H | | MAR 1 1982 | |
| 25b. REGISTRAR'S SIGNATURE | | 25c. REGISTRAR'S SIGNATURE | | 25d. REGISTRAR'S SIGNATURE | | 25e. REGISTRAR'S SIGNATURE | | 25f. REGISTRAR'S SIGNATURE | | 25g. REGISTRAR'S SIGNATURE | |
| | | | | | | | | | | | |



STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 2 0 3 9 5 5

1- FOR
STATE
REGISTRAR

REG. NO.

| | | | | | | | | | | | |
|--|--|---|--|---|--|--|---|--|--|--|--|
| 1. DECEASED NAME
(TYPE OR PRINT)
Annie Lee | | | 2a. DATE OF DEATH
MONTH DAY YEAR
2-27-82 | | | 2b. HOUR
MIN.
12:18P | | | | | |
| 3 SEX
FEMALE | | 4 RACE
BLACK | | 5. DATE OF BIRTH
MONTH DAY YEAR
11-8-96 | | 6. AGE (IN YEARS LAST BIRTHDAY)
YRS.
85 | | IF UNDER 1 YEAR
MONTHS DAYS
IF UNDER 24 HRS.
HOURS MIN. | | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
Dorchester Co. Md | | 7b. CITIZEN OF WHAT COUNTRY?
U.S.A. | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
Baltimore City | | | MD. | | |
| 10. CITY OR TOWN OF DEATH
Baltimore | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
John Hopkins Hospital | | | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
Housewife | | 12b. KIND OF BUSINESS OR INDUSTRY | | | |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)
13a. STATE
MARYLAND | | | 13b. COUNTY
BALTIMORE | | 13c. CITY OR TOWN
BALTIMORE | | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS
1807 E. Chase Street | | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
Lincoln Stafford | | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
Julia Spicer | | | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES AND IF UNKNOWN)
NO | | | 16b. SOCIAL SECURITY NO.
220-22-2389 | | |
| 17. INFORMANT
ADDRESS
Balt. Md. | | | 17. INFORMANT
ADDRESS
21227 | | | 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART 1. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) respiratory failure
DUE TO, OR AS A CONSEQUENCE OF
(b) interstitial fibrosis
DUE TO, OR AS A CONSEQUENCE OF
(c) marfan | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
18 hrs. | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER NOTIFY MEDICAL EXAMINER) | | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | | | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/> | | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from Feb 27 , 19 82 , to Feb 27 , 19 82 , that (I) (we) last saw the deceased alive on Feb 27 , 19 82 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) did (did not) view the body after death. | | | | | | | | | | | |
| 22b. SIGNATURE
A. Stephens | | | DEGREE | | | ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> | | | 22c. DATE SIGNED
2/27/82 | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
A. STEPHENS, MD | | | 22e. ADDRESS
John Hopkins Hospital | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)
BURIAL | | | 23b. DATE
3-6-82 | | 23c. NAME OF CEMETERY OR CREMATORY
Linas Road Cemetery | | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
Linas Rd, Dorchester Co. Md. | | | |
| 24. FUNERAL DIRECTOR
NAME
William J. Spaw | | | ADDRESS
1639 N. Broadway | | | 25a. DATE REC'D. BY REGISTRAR
MAR 2 1982 | | 25b. REGISTRAR'S SIGNATURE
Thomas J. Hester | | | |

1. The first part of the report
 2. The second part of the report
 3. The third part of the report
 4. The fourth part of the report
 5. The fifth part of the report
 6. The sixth part of the report
 7. The seventh part of the report
 8. The eighth part of the report
 9. The ninth part of the report
 10. The tenth part of the report

11. The eleventh part of the report
 12. The twelfth part of the report
 13. The thirteenth part of the report
 14. The fourteenth part of the report
 15. The fifteenth part of the report
 16. The sixteenth part of the report
 17. The seventeenth part of the report
 18. The eighteenth part of the report
 19. The nineteenth part of the report
 20. The twentieth part of the report

Item 236 G 564 2/17/82 GAB

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 2 0 3 9 5 6

1- FOR
STATE
REGISTRAR

REG. NO.

| | | | | | | | | | | |
|--|--|--|--|---|--|--|---|--|--|--|
| 1. DECEASED NAME
(TYPE OR PRINT)
JOEL LEE | | | 2a. DATE OF DEATH
MONTH DAY YEAR
02/11/82 | | | 2b. HOUR
8:30A | | | | |
| 3. SEX
MALE | | 4. RACE
BLACK | | 5. DATE OF BIRTH
MONTH DAY YEAR
5 11 11 | | 6. AGE [IN YEARS (LAST BIRTHDAY)]
70 YRS. | | IF UNDER 1 YEAR
MONTHS DAYS
IF UNDER 24 HRS.
HOURS MIN. | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
VIRGINIA | | 7b. CITIZEN OF WHAT COUNTRY?
USA | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
BALTIMORE CITY MD. | | | | |
| 10. CITY OR TOWN OF DEATH
BALTIMORE | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN BALTIMORE, GIVE STREET ADDRESS)
JOHNS HOPKINS HOSPITAL | | | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE) | | 12b. KIND OF BUSINESS OR INDUSTRY | | |
| 13a. STATE
MD. | | | 13b. COUNTY | | 13c. CITY OR TOWN
BALTIMORE | | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS
501 E. PRESTON ST. | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST | | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
YES | | | 16b. SOCIAL SECURITY NO.
155-03-1478 | | 17. INFORMANT
ADDRESS
CARTHION J. CARTER 5124 LAUREL AVE. | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART 1. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Stroke - Cerebrovascular Accident
4360
DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last
(b) _____
DUE TO, OR AS A CONSEQUENCE OF
(c) _____
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) _____ | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | | | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/> | | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from Jan 30 19 82 , to Feb 11 19 82 , that (I) (we) lost saw the deceased alive on Feb 11 19 82 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | | |
| 22b. SIGNATURE
Francine Welty | | | | | | DEGREE
ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> | | 22c. DATE SIGNED
2/11/82 | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
Francine Welty | | | | | | 22e. ADDRESS
Johns Hopkins Hospital | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)
BURIAL | | | 23b. DATE
2/17/82 | | 23c. NAME OF CEMETERY OR CREMATORY
MD. VETERANS CEMETERY | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
CHELTENHAM | | | |
| 24. FUNERAL DIRECTOR
NAME ADDRESS
WM. C. MARCH F/H 1101 E. NORTH AVENUE | | | | | | 25a. DATE REC'D. BY REGISTRAR
FEB 16 1982 | | | | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of same.



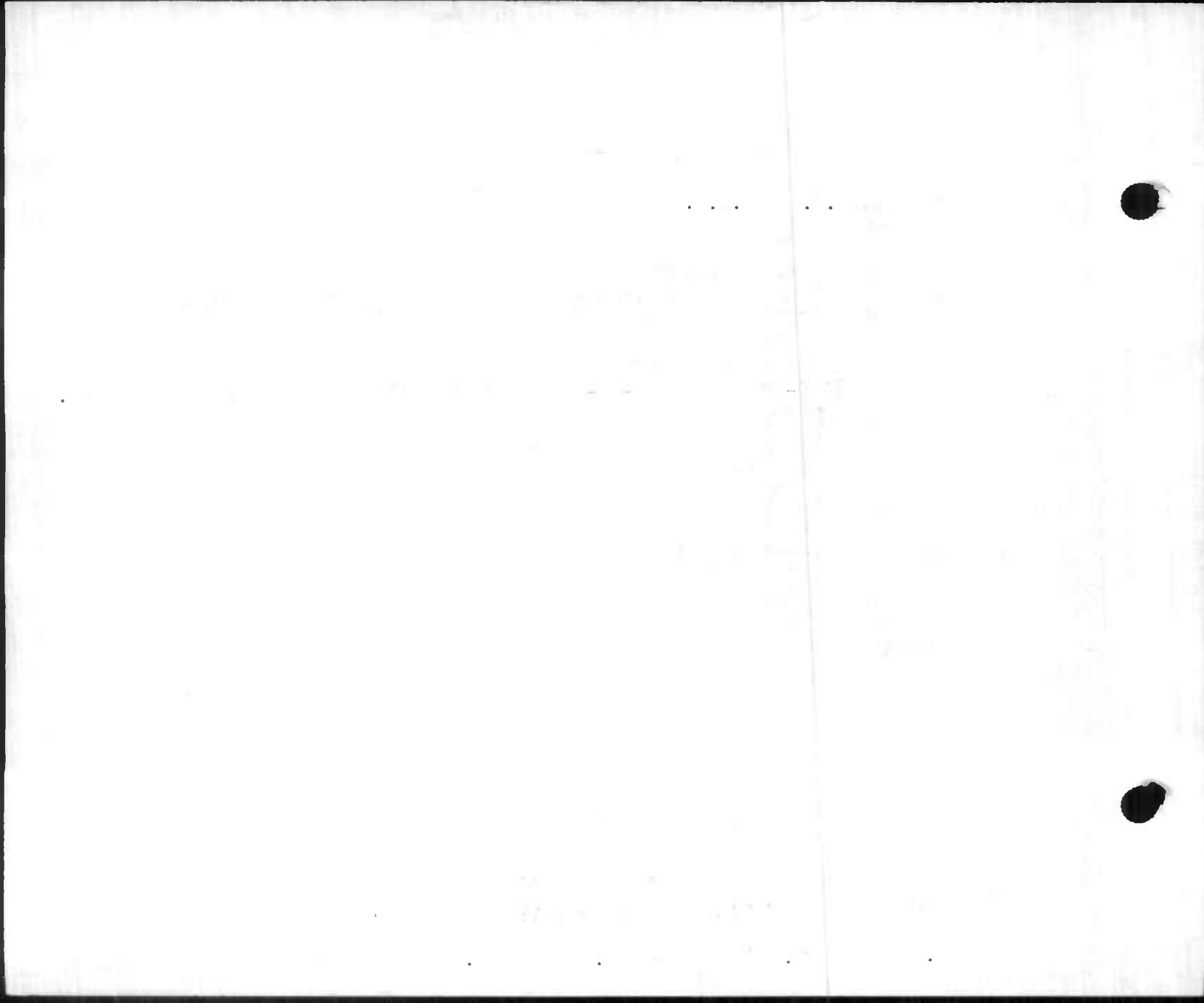
MASSACHUSETTS

MASSACHUSETTS

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 17 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

MEDICAL CERTIFICATION

| STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH | | | | | | | | | | REG. NO. 2 0 3 9 5 1 | | | | |
|--|--|-----------------------------|-------------|--|--|--|--|--|--|--|--|--|--|--|
| 1- FOR STATE REGISTRAR | | | | | | | | | | | | | | |
| 1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST
Joseph Lee | | | | | | 2a. DATE KNOWN OF DEATH ESTIMATED MONTH DAY YEAR
XX 2 18 19 82 | | 2b. HOUR
M | | | | | | |
| 3. SEX
male | | 4. RACE
black | | 5. DATE OF BIRTH MONTH DAY YEAR
10 12 19 10 | | 6. AGE (IN YEARS) (LAST BIRTHDAY) MONTHS DAYS HOURS MIN.
71 YRS. | | 7c. DATE PRONOUNCED DEAD MONTH DAY YEAR
2 18 19 82 | | 2d. HOUR
8:17 P | | | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
Wilmington, N.C. | | | | 7b. CITIZEN OF WHAT COUNTRY?
U.S.A. | | | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
Baltimore City MD | | | | |
| 10. CITY OR TOWN OF DEATH
Baltimore | | | | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
Sinai Hospital | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | | 12b. KIND OF BUSINESS OR INDUSTRY | | | | |
| USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) | | | | | | | | | | | | | | |
| 13a. STATE
Maryland | | | 13b. COUNTY | | | 13c. CITY OR TOWN
Baltimore | | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | 13e. STREET ADDRESS
4025 Reisterstown Road | | |
| 14. FATHER'S NAME FIRST MIDDLE LAST | | | | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST | | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)
Yes | | | | 16b. SOCIAL SECURITY NO.
1944-46 | | 17. INFORMANT ADDRESS
Lula Bell Lee 4025 Reisterstown Rd. | | | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I DEATH WAS CAUSED BY: 4029 Hypertensive & arteriosclerotic cardiovascular disease
IMMEDIATE CAUSE (a) 4029 DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. (b) DUE TO, OR AS A CONSEQUENCE OF
(c) | | | | | | | | | | | | | | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I | | | | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | | | | | | 20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
P.M. 19 | | | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR | | | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2) | | | | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK | | | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) | | | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | | | | |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> | | | | | | | | | | | | | | |
| ACTUAL SIGNATURE Margarita A. Korell | | | | TITLE (SPECIFY) M.D. Assistant MEDICAL EXAMINER | | | | DATE SIGNED 2/19/82 | | | | | | |
| EXAMINER'S NAME (TYPE OR PRINT) Margarita A. Korell, M.D. | | | | ADDRESS 111 Penn Street, Balto MD 21201 | | | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)
Burial | | 23b. DATE
2/23/82 | | 23c. NAME OF CEMETERY OR CREMATORY
Crownsville Cemetery | | | | 23d. LOCATION CITY OR TOWN COUNTY STATE
Crownsville MD | | | | | | |
| 24. FUNERAL DIRECTOR NAME Wm C. Brown Comm. F/H ADDRESS 1206-08 W. North Ave. | | | | | | 25a. DATE REC'D. BY REGISTRAR
MAR 2 1982 | | 25b. REGISTRAR'S SIGNATURE James Van Notten | | | | | | |



BP

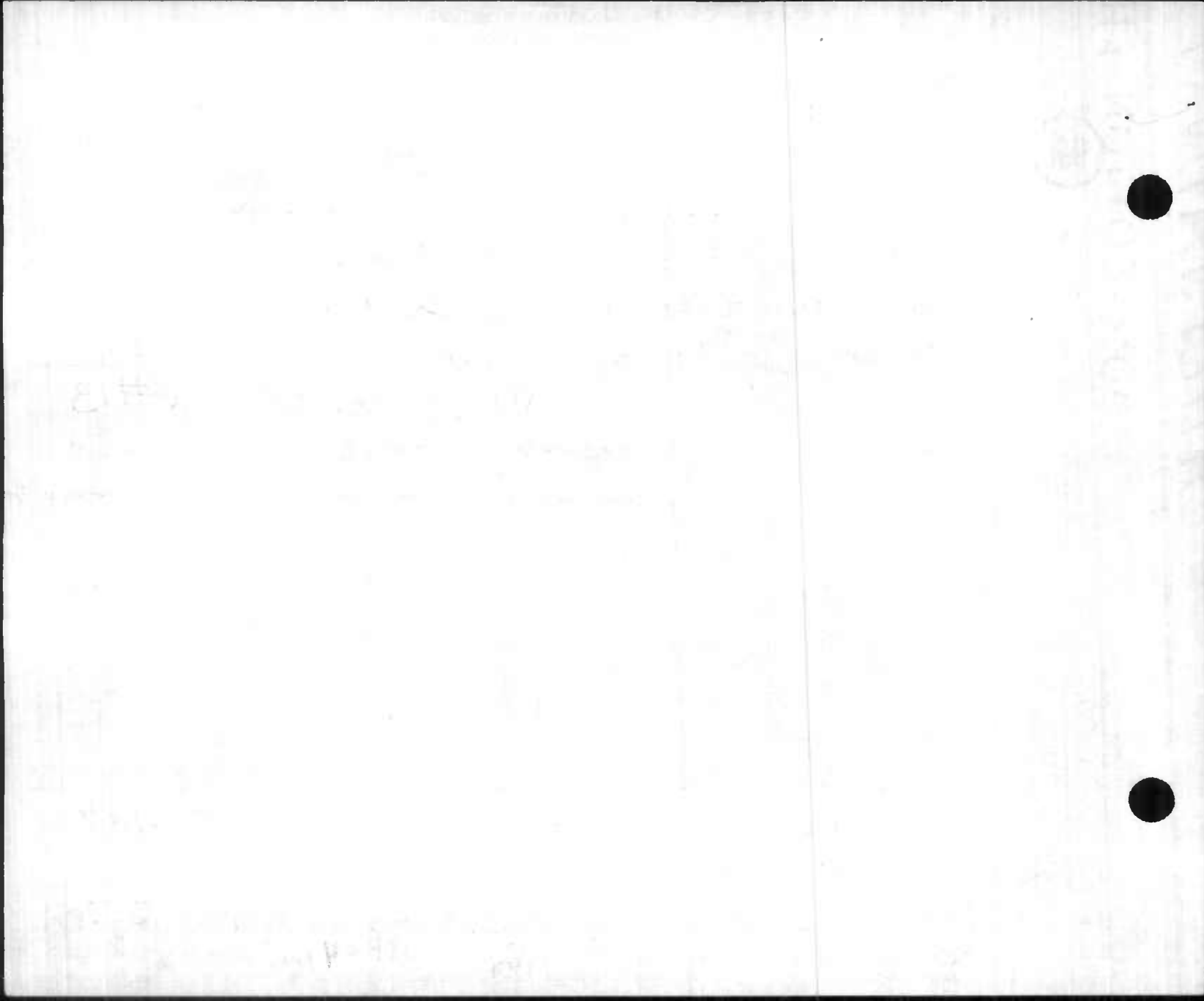
DHMH - 16 50M 1/81
(VRA 15, 4)

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

| STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH | | | | 8 2 0 3 7 5 8 | | | |
|--|--|---|--|--|--|---|--|
| 1 - FOR STATE REGISTRAR | | | | REG. NO. | | | |
| 1 DECEASED NAME
(TYPE OR PRINT)
FIRST MIDDLE LAST
MARIO LEONE | | | | 2a DATE OF DEATH
MONTH DAY YEAR
2 19 82 | | 2b HOUR
4:45 a.m. | |
| 3 SEX
MALE | | 4 RACE
WHITE | | 5 DATE OF BIRTH
MONTH DAY YEAR
11 7 11 | | 6 AGE (IN YEARS LAST BIRTHDAY)
70 | |
| 7a BIRTHPLACE (STATE OR FOREIGN COUNTRY)
NEW YORK | | 7b CITIZEN OF WHAT COUNTRY?
U.S.A. | | 8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9 BALTIMORE CITY OR COUNTY OF DEATH
Baltimore City, MD | |
| 10 CITY OR TOWN OF DEATH
BALTIMORE | | 11 NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
VAMC BALTIMORE, MARYLAND 21218 | | 12a USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
House Painter Construction | | 12b KIND OF BUSINESS OR INDUSTRY | |
| 13a STATE
MARYLAND | | | | 13b COUNTY
Calvert | | 13c CITY OR TOWN
SUNDERLAND | |
| 14 FATHER'S NAME
FIRST MIDDLE LAST
Joseph Leone | | 15 MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
Lucia Ruffo | | 13d INSIDE CITY LIMITS?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 16a WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
YES | | 16b SOCIAL SECURITY NO.
(IF YES, GIVE WAR DATES)
WWT 577 12 9422 | | 17 INFORMANT ADDRESS
Maryheone same as #13 | | | |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART 1. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) respiratory arrest
DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last
b) cryptococcal sepsis
DUE TO, OR AS A CONSEQUENCE OF
c)
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
minutes
13 days | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:
hepatic cirrhosis, disseminated intravascular coagulation | | | | | | | |
| 19a DATE OF OPERATION
none | | 19b CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | |
| 21d INJURY OCCURRED
WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21e PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f LOCATION
STREET CITY OR TOWN COUNTY STATE | | | |
| 22a I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from FEBRUARY 5, 19 82 to FEBRUARY 19, 19 82 , that <input checked="" type="checkbox"/> (we) lost the deceased alive on FEBRUARY 19, 19 82 , and that in <input checked="" type="checkbox"/> (our) opinion death occurred on the date and hour and from the causes stated above, (I) <input checked="" type="checkbox"/> (we) <input type="checkbox"/> (did) <input type="checkbox"/> (did not) view the body after death. | | | | | | | |
| 22b SIGNATURE
Bruce Rosenberg | | | | DEGREE
M.D. | | 22c DATE SIGNED
2/19/82 | |
| 22d PHYSICIAN'S NAME (TYPE OR PRINT)
BRUCE ROSENBERG | | | | 22e ADDRESS
LOCH RAVEN V.A. Hosp. | | | |
| 23a BURIAL, CREMATION, REMOVAL
(SPECIFY)
Burial | | 23b DATE
2/22/82 | | 23c NAME OF CEMETERY OR CREMATORY
Mal Veterans Cemetery | | 23d LOCATION
CITY OR TOWN COUNTY STATE
Cheltenham PG Md | |
| 24 FUNERAL DIRECTOR
NAME ADDRESS
Raboch Funeral Home Owings Md | | | | 25a DATE REC'D. BY REGISTRAR
FEB 24 1982 | | | |
| | | | | 25b REGISTRAR'S SIGNATURE
[Signature] | | | |



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841



| STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH | | | | | | | | | | REG. NO. 8 2 0 3 9 5 9 | | | | | | | |
|---|--|---|--|---|--|--|--|--|--|--|--|---|--|----------|--|-----------|--|
| 1. FOR STATE REGISTRAR | | | | | | | | | | 2a. DATE OF DEATH | | | | 2b. HOUR | | | |
| 1 DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST
GEORGE B. LEVASSEUR Sr. | | | | | | | | | | 2 | | 1 | | 82 | | 8:28 p.m. | |
| 3 SEX
male | | 4 RACE
Cauc. White | | 5. DATE OF BIRTH
MONTH DAY YEAR
7 - 27 - 05 | | 6. AGE (IN YEARS LAST BIRTHDAY)
76 YRS | | IF UNDER 1 YEAR
MONTHS DAYS HOURS MIN | | | | | | | | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
MAINE | | 7b. CITIZEN OF WHAT COUNTRY?
USA | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
Baltimore, City MD. | | | | | | | | | | | |
| 10. CITY OR TOWN OF DEATH
Baltimore | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
St. Agnes Hospital | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)
Refrig. Mechanic | | 12b. KIND OF BUSINESS OR INDUSTRY
Retired, Eckas Corp. | | | | | | | | | |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)
13a. STATE
Md | | 13b. COUNTY
Howard | | 13c. CITY OR TOWN
Columbia | | 13d. INSIDE CITY LIMITS?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS
6200 G Foreland Garth | | | | | | | | | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
Edward Levasseur | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
Sophia Jacques | | | | | | | | | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)
Yes | | 16b. SOCIAL SECURITY NO.
1931-1935 | | 17. INFORMANT
Martha Levasseur | | ADDRESS
Same as # 13 | | | | | | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Acute tracheobronchitis
5010
DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last:
(b) Pulmonary emphysema + fibrosis
DUE TO, OR AS A CONSEQUENCE OF
(c) Questionable asbestosis (Pt has pleural plaques) | | | | | | | | | | APPROPRIATE INTERVAL BETWEEN ENTRY AND DEATH | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR FOUNDATION GIVEN IN PART I (a):
Intestinal obstruction + fibrous peritoneal adhesions | | | | | | | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | | | | | | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) | | | | | | | | | | | | | |
| 21d. INJURY OCCURRED
WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | | | | | | | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 3/1 , 19 82 , to 3/1 , 19 82 ; that (I) (we) lost saw the deceased alive on 3/1 , 19 82 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above (I) (we) (did) (did not) view the body after death. | | | | | | | | | | | | | | | | | |
| 22b. SIGNATURE
William J Hicken | | DEGREE
M.D. | | ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> | | 22c. DATE SIGNED
3/2/82 | | | | | | | | | | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
William J Hicken | | 22e. ADDRESS
St Agnes Hospital | | | | | | | | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)
Burial | | 23b. DATE
2/5/82 | | 23c. NAME OF CEMETERY OR CREMATORY
Dulaney Valley Memorial | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
Timonium Md. | | | | | | | | | | | |
| 24. FUNERAL DIRECTOR NAME
Witzke P.A. | | ADDRESS
5555 Twin Knolls Road, Columbia, Md. 21045 | | 25a. DATE REC'D. BY REGISTRAR
FEB 3 1982 | | 25b. REGISTRAR'S SIGNATURE
Thomas J. [Signature] | | | | | | | | | | | |

[Faint, illegible text throughout the page, likely bleed-through from the reverse side.]

1905

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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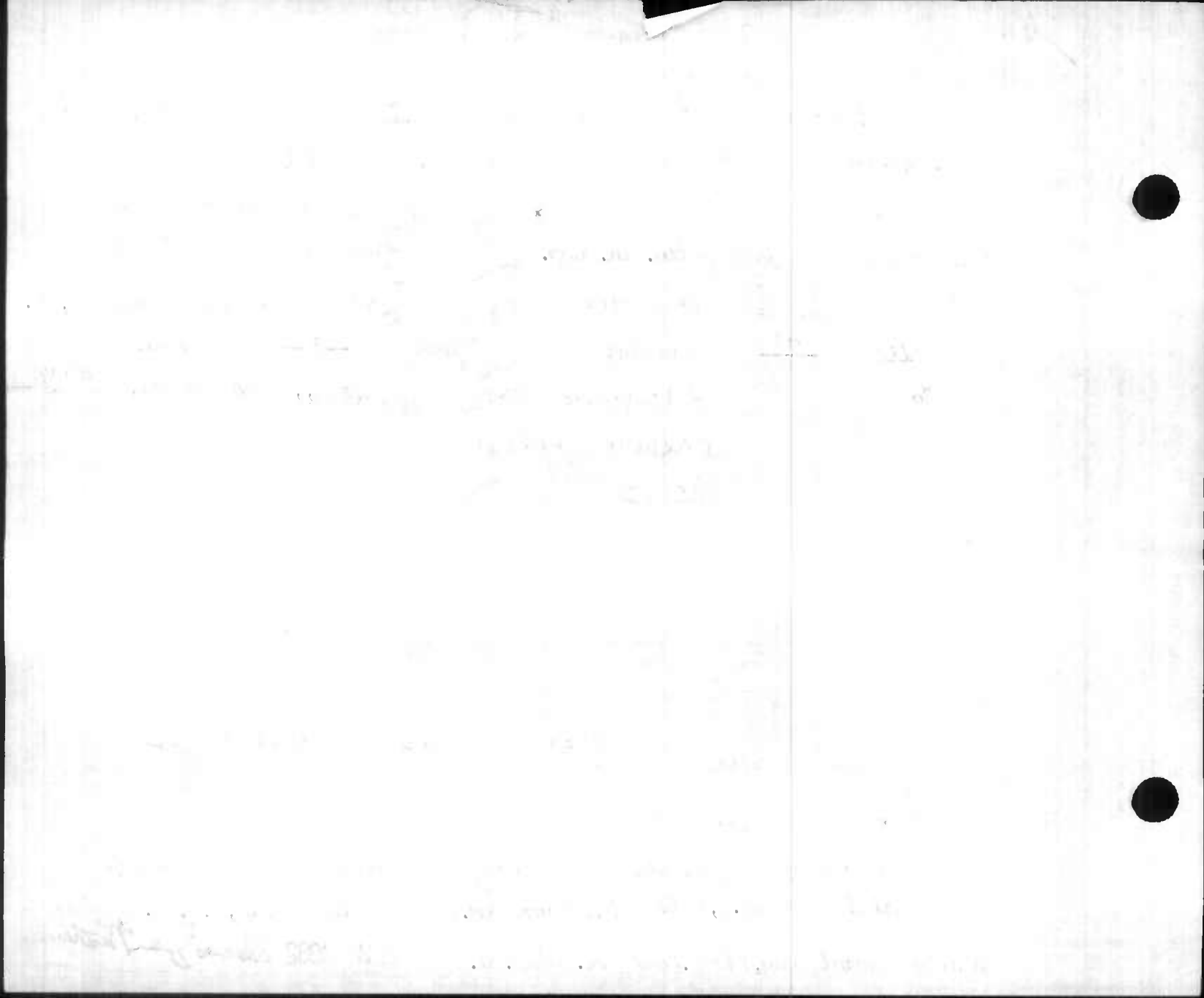
FOR
STATE
REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 2 0 3 9 6 0
REG. NO.

| | | | | | | | | |
|--|--|---|--|---|--|---|--|--|
| 1- DECEASED NAME
(TYPE OR PRINT) BESSIE G LEWIS | | | 2a. DATE OF DEATH
MONTH DAY YEAR FEB. 27, 1982 | | | 2b. HOUR
9⁴⁵ M. | | |
| 3. SEX
FEMALE | | 4. RACE
Caucasian | | 5. DATE OF BIRTH
MONTH DAY YEAR 02-13-02 | | 6. AGE (IN YEARS LAST BIRTHDAY)
80 YRS. | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
MD | | 7b. CITIZEN OF WHAT COUNTRY?
USA | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
CITY Baltimore MD. | | |
| 10. CITY OR TOWN OF DEATH
BALTIMORE | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
South Balto. Gen. Hoap. | | | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
Seamstress | | 12b. KIND OF BUSINESS OR INDUSTRY
(Nothing) |
| 13a. STATE
MD | | 13b. COUNTY
H.A. | | 13c. CITY OR TOWN
BALTIMORE | | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS
311 EDISON ST. Brooklyn, Md. |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
Ollie --- Buckler | | | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
Mary --- Cusick | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
No | | 16b. SOCIAL SECURITY NO.
217-01-0148 | | 17. INFORMANT
ADDRESS
GRAND DAUGHTER, Joann Wergert, Same as above | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) CARDIAC ARREST
4292
DUE TO, OR AS A CONSEQUENCE OF
(b) ASCVD
DUE TO, OR AS A CONSEQUENCE OF
(c) _____
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a): | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2) | | | | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 2/27 - 19 82 , to 2/27 19 82 , that (I) (we) last saw the deceased alive on 2/27 19 82 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (If we) (I) did not view the body after death. | | | | | | | | |
| 22b. SIGNATURE
Alex Kosenko | | | | DEGREE
ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> | | | 22c. DATE SIGNED | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
ALEXANDER KOSENKO | | | | 22e. ADDRESS
3001 S. HANOVER ST. 21230 | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)
Burial | | 23b. DATE
Mar. 3, 1982 | | 23c. NAME OF CEMETERY OR CREMATORY
Glen Haven Mem. Park | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
Glen Burnie, A. Co. Maryland | | |
| 24. FUNERAL DIRECTOR
NAME ADDRESS
McCully Funeral Home, 130 E. Forest Ave. Balto. Md. | | | | 25a. DATE REC'D. BY REGISTRAR
MAR 2 1982 | | 25. REGISTRAR
Charles J. Nathan | | |

BP



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 2 0 3 9 6 1

REG. NO.

1 - FOR
STATE
REGISTRAR

| | | | | | | | |
|---|--|--|--|---|---------------------------|--|--|
| 1. DECEASED NAME
(TYPE OR PRINT)
FIRST MIDDLE LAST
CATHERINE Lewis | | | 2a. DATE OF DEATH
MONTH DAY YEAR
02 - 19 - 82 | | 2b. HOUR
7:20pm | | |
| 3. SEX
FEMALE | | 4. RACE
W | | 5. DATE OF BIRTH
MONTH DAY YEAR
10 - 18 - 99 | | 6. AGE (IN YEARS LAST BIRTHDAY)
82
YRS. MONTHS DAYS HOURS MIN. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
MD. | | 7b. CITIZEN OF WHAT COUNTRY?
U.S. | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
CITY MD. | |
| 10. CITY OR TOWN OF DEATH
BALTIMORE | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
LUTHERAN HOSP. OF MARYLAND | | | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
NONE | |
| 13a. STATE
MD | | 13b. COUNTY
BALTO | | 13c. CITY OR TOWN
BALTIMORE | | 13d. INSIDE CITY LIMITS?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 13e. STREET ADDRESS
P.O. BOX 3235 | | 14. FATHER'S NAME
FIRST MIDDLE LAST
? ? ? | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
? ? ? | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
Unkn. | | 16b. SOCIAL SECURITY NO.
030 14 8745 | | 17. INFORMANT
ADDRESS
NEHM T. THAUNG LUTHERAN HOSP. OF MD, INC. | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART 1. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Sepsis, Renal Failure, Respiratory Failure
8970
DUE TO, OR AS A CONSEQUENCE OF
(b) _____
DUE TO, OR AS A CONSEQUENCE OF
(c) _____
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) | | | | | | | |
| 19a. DATE OF OPERATION
1 - 13 - 82 | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED
Left Below Knee Amputation | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) | | | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 12 - 14 - 19 81 , to 02 - 19 - 19 82 , that (I) (we) last saw the deceased alive on 02 - 19 - 19 82 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | |
| 22b. SIGNATURE
Neem Thein Thaung | | DEGREE
MD | | ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> | | 22c. DATE SIGNED
02 - 19 - 82 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
NEEM THEIN THAUNG | | 22e. ADDRESS
LUTHERAN HOSP. OF MARYLAND INC. | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)
Removal | | 23b. DATE
2/22/82 | | 23c. NAME OF CEMETERY OR CREMATORY | | 23d. LOCATION
CITY OR TOWN COUNTY STATE | |
| 24. FUNERAL DIRECTOR
NAME
Anatomy Board | | | | ADDRESS
Balto., Md. | | 25a. DATE REC'D. BY REGISTRAR
FEB 6 6 1982 | |

RECEIVED
U.S. AIR FORCE
210-210

1957

RECEIVED

210-210

210-210

DHMH-16 30M 2/80
(VRA 15, 4)

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. It must be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH | | | | | | | | | | 8 2 0 3 9 6 2 | |
|---|--|---|--|---|--|---|--|---|--|---------------|--|
| 1. FOR STATE REGISTRAR | | REG. NO. | | | | | | | | | |
| 1. DECEASED NAME
(TYPE OR PRINT) FIRST MIDDLE LAST
CHARLES J. LEWIS, JR. | | | | | | 2a. DATE OF DEATH MONTH DAY YEAR
2 28 82 | | 2b. HOUR
M | | | |
| 3. SEX
Male | | 4. RACE
White | | 5. DATE OF BIRTH MONTH DAY YEAR
2 3 02 | | 6. AGE (IN YEARS LAST BIRTHDAY) YRS.
80 | | IF UNDER 1 YEAR MONTHS DAYS
IF UNDER 24 HRS. HOURS MIN. | | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
Md. | | 7b. CITIZEN OF WHAT COUNTRY?
U.S.A. | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
Balto. City MD. | | | | | |
| 10. CITY OR TOWN OF DEATH
Balto. | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
2914 Overland Ave. | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)
Security Guard | | 12b. KIND OF BUSINESS OR INDUSTRY | | | |
| 13a. STATE
Md. | | 13b. COUNTY | | 13c. CITY OR TOWN
Balto. | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS
2914 Overland Ave. | | | |
| 14. FATHER'S NAME FIRST MIDDLE LAST
Charles J. Lewis, Sr. | | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST
Hannah | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)
No | | 16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES)
220-09-5661A | | 17. INFORMANT ADDRESS
Mr. Russell Lewis Balto., Md. | | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART 1. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>cardiorespiratory arrest</u>
DUE TO, OR AS A CONSEQUENCE OF (b) <u>carcinoma of lung</u>
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. } DUE TO, OR AS A CONSEQUENCE OF (c)
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
6 mos. | | | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)
<u>chronic obstructive pulmonary disease</u> | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | | | | | |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from _____, 19____, to <u>November</u> , 19 <u>81</u> , that (I) (we) lost the deceased alive on <u>November</u> , 19 <u>81</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | | | |
| 22b. SIGNATURE
<u>Jan M. Bathon MD</u> | | | | | | DEGREE
ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | 22c. DATE SIGNED | | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
<u>Bathon MD</u> | | | | 22e. ADDRESS
<u>Univ Hospital, Balto, Md. 21201</u> | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)
Removal | | 23b. DATE
2/28/82 | | 23c. NAME OF CEMETERY OR CREMATORY | | 23d. LOCATION CITY OR TOWN COUNTY STATE | | | | | |
| 24. FUNERAL DIRECTOR NAME
Anatomy Board | | | | ADDRESS
Balto., Md. | | 25a. DATE REC'D. BY REGISTRAR
MAR 8 1982 | | 25b. REGISTRAR'S SIGNATURE
<u>James J. [Signature]</u> | | | |

MEDICAL CERTIFICATION

2702 BP

1940

1941

1942

1943

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

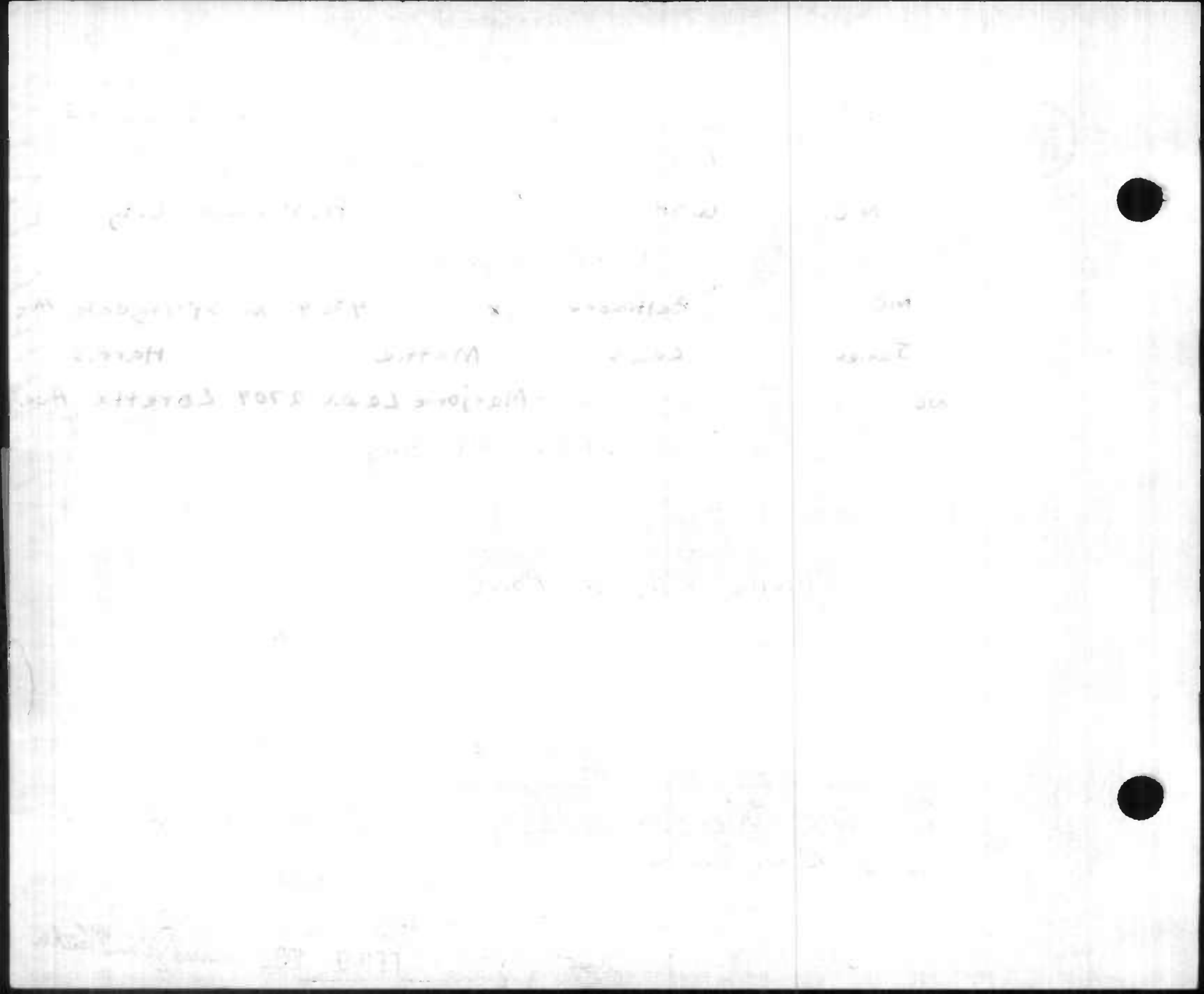
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 2 0 3 7 6 3

| | | | | | |
|--|---|---|--|---|--|
| 1. DECEASED NAME
(TYPE OR PRINT)
FIRST MIDDLE LAST
SANDY LEWIS | | 2a. DATE OF DEATH
MONTH DAY YEAR
2 7 82 | | 2b. HOUR
MIN.
1A | |
| 3. SEX
Male | 4. RACE
Black | 5. DATE OF BIRTH
MONTH DAY YEAR
7 16 30 | | 6. AGE (IN YEARS LAST BIRTHDAY)
YRS MONTHS DAYS HOURS MIN.
51 | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
N.C. | 7b. CITIZEN OF WHAT COUNTRY?
U.S.A | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
Baltimore City MD. | |
| 10. CITY OR TOWN OF DEATH
Baltimore | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
Grna Hospital | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE) | | 12b. KIND OF BUSINESS OR INDUSTRY |
| 13a. STATE
MD | | 13b. COUNTY
Baltimore | 13c. CITY OR TOWN
Baltimore | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | 13e. STREET ADDRESS
4304 N. Springdale Ave |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
James Lewis | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
Mattie Harris | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
NO | | 16b. SOCIAL SECURITY NO.
246-38-5784 | | 17. INFORMANT
ADDRESS
Marjorie Lewis 2704 Loretta Ave. | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART 1. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Gastro-Intestinal Bleeding
5789
DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b) _____
DUE TO, OR AS A CONSEQUENCE OF
(c) _____ | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:
Chronic Ethanol Abuse | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | |
| 22a. I certify that (I) (this hospital) attended the deceased from February 2, 19 82 , to Feb 7, 19 82 , that (I) (we) last saw the deceased alive on 2-7, 19 82 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | |
| 22b. SIGNATURE
Elio Raul Novoa | | | | 22c. DATE SIGNED
2-7-82 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
Elio Raul Novoa | | | | 22e. ADDRESS | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)
Burial | | 23b. DATE
2/11/82 | | 23c. NAME OF CEMETERY OR CREMATORY
Mt. Calvary Cem. | |
| 23d. LOCATION
CITY OR TOWN COUNTY STATE
Baltimore Co. MD | | 24. FUNERAL DIRECTOR
NAME ADDRESS
Wm. C. March F/H 1101 E. North Ave. | | | |
| 25a. DATE REC'D. BY REGISTRAR
FEB 9 1982 | | 25b. REGISTRAR'S SIGNATURE
Frances Jan Nathan | | | |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP

DHMH - 16 50M 1/81
(VRA 15, 4)

| STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH | | | | | | | | | | 8 2 0 3 9 6 4 | | | |
|---|--|---|--|--|--|---|--|--|--|---|--|--|--|
| 1 - FOR STATE REGISTRAR | | REG. NO. | | | | | | | | | | | |
| 1. DECEASED NAME (TYPE OR PRINT) | | FIRST
JESSIE | | MIDDLE
C. | | LAST
LICKLETER | | 2a. DATE OF DEATH | | MONTH
2-8-82 | | DAY
7:31a | |
| 3 SEX
FEMALE | | 4 RACE
WHITE | | 5. DATE OF BIRTH | | MONTH
March 15, 1929 | | YEAR
1929 | | 6 AGE (IN YEARS LAST BIRTHDAY)
52 | | 7a. IF UNDER 1 YEAR
MONTHS
DAYS
HOURS
MIN. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
WASHINGTON DC | | 7b. CITIZEN OF WHAT COUNTRY?
USA | | 8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9 BALTIMORE CITY OR COUNTY OF DEATH
BALTIMORE CITY | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)
Cashier | | 12b. KIND OF BUSINESS OR INDUSTRY
G.S.I. | | MD. | |
| 10. CITY OR TOWN OF DEATH
BALTIMORE | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
ST. AGNES HOSPITAL | | 12c. STREET ADDRESS
5200 Ballman Avenue | | 13a. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13b. STREET ADDRESS
5200 Ballman Avenue | | 13c. CITY OR TOWN
Brooklyn | | 13d. STATE
Maryland | |
| 14 FATHER'S NAME | | 15. MOTHER'S MAIDEN NAME | | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
NO | | 16b. SOCIAL SECURITY NO.
577-42-8823H | | 17 INFORMANT
Connie E. Torrillo | | 17a. ADDRESS
7401 Eastmoreland Road
Annandale, Va 22003 | | 17b. (Daughter) #821 | |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY
IMMEDIATE CAUSE (a) metastatic disease
1629
DUE TO, OR AS A CONSEQUENCE OF
(b) Lung cancer
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO, OR AS A CONSEQUENCE OF
(c) | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: | | | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | | | | | | | |
| 21d. INJURY OCCURRED
WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | | | | | | | |
| 22a. I certify that (i) (this hospital) attended the deceased from 3/1 19 82 , to 2/8 19 82 , that (ii) (we) lost saw the deceased alive on 2/5 19 82 , and that in my (our) opinion death occurred on the date and hour and from the causes stated above, (ii) (we) (did) (did not) view the body after death. | | | | | | | | | | | | | |
| 22b. SIGNATURE
<i>Steven M. Samuels</i> | | DEGREE
M.D. | | ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> | | 22c. DATE SIGNED
2/8/82 | | | | | | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
Steven M. Samuels | | 22e. ADDRESS
St. Agnes Hospital, Baltimore, Md. | | | | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL
Burial | | 23b. DATE
2/10/82 | | 23c. NAME OF CEMETERY OR CREMATORY
Ft. Lincoln Cemetery | | 23d. LOCATION
Brentwood P.G. Maryland | | | | | | | |
| 24. FUNERAL DIRECTOR
Francis Gasch's Sons Funeral Home, P.A. | | ADDRESS
Hyattsville, Maryland | | 25a. DATE REC'D. BY REGISTRAR
FEB 16 1982 | | 25b. REGISTRAR'S SIGNATURE
<i>James Gasch</i> | | | | | | | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Persons retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

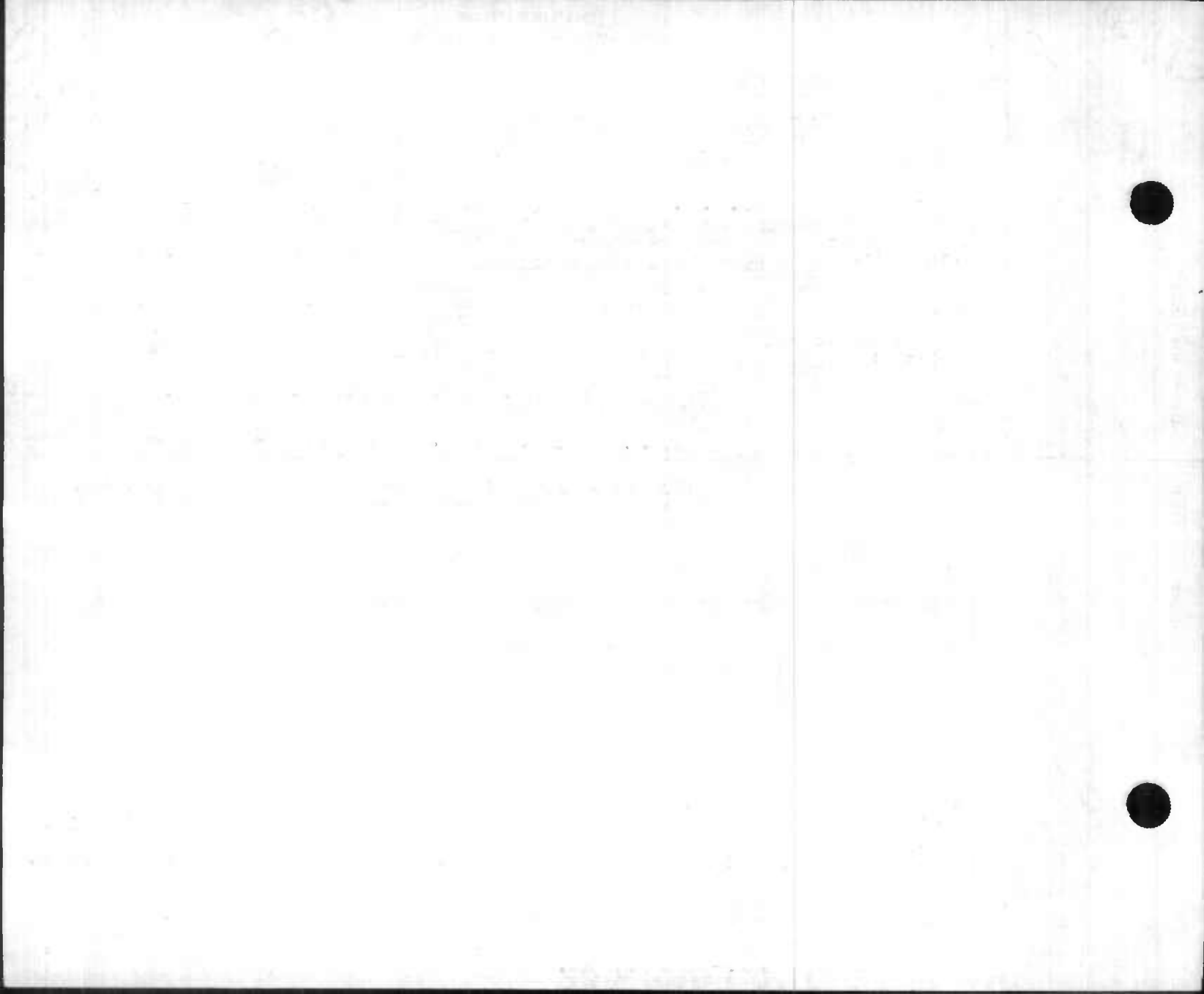
FOR
1- STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | |
|--|--|---|--|--|---|
| 1 DECEASED NAME
(TYPE OR PRINT)
FIRST Joseph MIDDLE Lieb LAST Lieb
JOSEPH LIEB | | 2a DATE OF DEATH
MONTH 2 DAY 6 YEAR 82 | | 2b HOUR 5 MIN 05 AM | |
| 3 SEX Male | | 4 RACE White | | 5 DATE OF BIRTH
MONTH 3 DAY 7 YEAR 15 | |
| 6 AGE (IN YEARS LAST BIRTHDAY)
66 YRS | | 7 UNDER 1 YEAR
MONTHS 66 DAYS 66 | | 8 UNDER 24 HRS
HOURS 66 MIN 66 | |
| 7a BIRTHPLACE (STATE OR FOREIGN COUNTRY)
Maryland | | 7b CITIZEN OF WHAT COUNTRY?
U.S.A. | | 8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | |
| 9 BALTIMORE CITY OR COUNTY OF DEATH
Balto. City MD. | | 10 CITY OF BIRTH
City Balto. | | 11 NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
Hamilton Nursing Center | |
| 12a USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
Clerk | | 12b KIND OF BUSINESS OR INDUSTRY
U.S. Gov't. | | 13a STATE
Maryland | |
| 13b COUNTY
Baltimore | | 13c CITY OR TOWN
Baltimore | | 13d INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 14 FATHER'S NAME
FIRST Mathias MIDDLE Lieb LAST Lieb | | 15 MOTHER'S MAIDEN NAME
FIRST Elizabeth MIDDLE Ull LAST Ull | | 16a WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)
No | |
| 16b ADDRESS
216-01-5990 | | 17 INFORMANT
Mr. Ed Carey (Atty.) | | 18 ADDRESS
2930 E. Baltimore St | |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY
IMMEDIATE CAUSE (a) Acute Myocardial infarction
4100
DUE TO, OR AS A CONSEQUENCE OF
(b) Coronary Atherosclerosis
DUE TO, OR AS A CONSEQUENCE OF
(c) years | | | | | APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATH
hours |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) | | | | | |
| 19a DATE OF OPERATION | | 19b CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a AUTOPSY?
YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | |
| 21d INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK AT WORK | | 21e PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f LOCATION
STREET CITY OR TOWN COUNTY STATE | |
| 22a I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) last saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | |
| 22b SIGNATURE
Dr. Gracito Patricio | | DEGREE
MD | | 22c DATE SIGNED
2/8/82 | |
| 22d PHYSICIAN'S NAME (TYPE OR PRINT)
Dr. Gracito Patricio | | 22e ADDRESS
2926 E. Cold Spring Lane - Balto., Md. | | | |
| 23a BURIAL, CREMATION, REMOVAL
(SPECIFY)
Burial | | 23b DATE
2/9/82 | | 23c NAME OF CEMETERY OR CREMATORY
Holy Redeemer | |
| 23d LOCATION
CITY OR TOWN
Baltimore, Md. | | COUNTY
Baltimore | | STATE
Md. | |
| 24 FUNERAL DIRECTOR
NAME
Schimunek Funeral Home, Inc.
3331 Brehms La.-Balto., Md. | | 25a DATE REC'D. BY REGISTRAR
FEB 9 1982 | | | |
| 25b REGISTRAR'S SIGNATURE
James J. [Signature] | | | | | |

MEDICAL CERTIFICATION

0701 BP



TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH, IF ANY DEATH IS NECESSARY. PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL ON ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE MEDICAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 4 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

Item #1 Film G565 3/5/82 rc

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

FOR
1- STATE
REGISTRAR

1. DECEASED NAME
(TYPE OR PRINT)

FIRST

Katrinia

MIDDLE

KATRINA

LAST

LITTLE

2a. DATE KNOWN
OF DEATH
ESTI-
MATED

MONTH DAY YEAR
2-5-82 19

2b. HOUR
M

3. SEX

female

4. RACE

black

5. DATE OF BIRTH

MONTH DAY YEAR
10 5 67

6. AGE (IN YEARS)

(LAST BIRTHDAY)
14 YRS.

IF UNDER 1 YR.

MONTHS DAYS
HOURS MIN.

IF UNDER 24 HRS.

7c. DATE

PRONOUNCED
DEAD

MONTH DAY YEAR
2-5-82 19

2d. HOUR
M

7a. BIRTHPLACE (STATE OR
FOREIGN COUNTRY)

MARYLAND

7b. CITIZEN OF WHAT COUNTRY?

US

8. MARRIED

NEVER MARRIED ☒
WIDOWED ☐ DIVORCED ☐

9. BALTIMORE CITY OR COUNTY OF DEATH

Baltimore City

MD.

10. CITY OR TOWN OF DEATH

Baltimore

11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION

(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
Belvedere Ave. & Groveland Ave.

12a. USUAL OCCUPATION (TYPE OF WORK)

STUDENT

12b. KIND OF BUSINESS

OR INDUSTRY

USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

13a. STATE

MARYLAND

13b. COUNTY

13c. CITY OR TOWN

BALTIMORE

13d. INSIDE CITY LIMITS?

YES ☒ NO ☐

13e. STREET ADDRESS

4001 GROVELAND AVENUE

14. FATHER'S NAME

GENE

MIDDLE

LITTLE

LAST

15. MOTHER'S MAIDEN NAME

ARUTHA

MIDDLE

ALLEN

LAST

16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO, OR UNKNOWN)

16b. SOCIAL SECURITY NO.
(IF YES, GIVE WAR OR DATES)

17. INFORMANT

ARUTHA LITTLE

ADDRESS

4001 GROVELAND AVE.

18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) Cranio-cerebral trauma

DUE TO, OR AS A CONSEQUENCE OF

8147
Conditions, if any, which
gave rise to immediate
cause (a) stating the under-
lying cause last.

(b) _____
DUE TO, OR AS A CONSEQUENCE OF

(c) _____

APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATH

PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)

19a. DATE OF OPERATION

19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?

20. AUTOPSY?

YES ☒ NO ☐

21a. EXTERNAL CAUSE WAS

UNDERLYING ☒ OR
CONTRIBUTING ☐ CAUSE OF DEATH

21b. TIME OF INJURY
HOUR MONTH DAY YEAR
7:14AM 2-5-82 19
P.M.

21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)

pedestrian struck by a bus

21d. INJURY OCCURRED

WHILE ☐ NOT WHILE ☐
AT WORK ☐ AT WORK ☒

21e. PLACE OF INJURY (AT HOME,
STREET, FACTORY, FARM, ETC.)

street

21f. LOCATION

STREET CITY OR TOWN COUNTY STATE
Belvedere & Groveland Avenues Balto., Maryland

22a. I certify that I took charge of the remains described above, held an Autopsy ☒ Inspection ☐ Inquiry ☐ and in my opinion
death resulted from: Natural causes ☐ Accident ☒ Suicide ☐ Homicide ☐ Undetermined manner ☐

ACTUAL
SIGNATURE

Margarita A. Korell

TITLE (SPECIFY)

M.D. Assistant MEDICAL EXAMINER

DATE SIGNED 2-5-82

EXAMINER'S NAME
(TYPE OR PRINT)

Margarita A. Korell, M.D.

ADDRESS 111 Penn Street

23a. BURIAL, CREMATION, REMOVAL

ENTOMBMENT

23b. DATE

2-9-82

23c. NAME OF CEMETERY OR CREMATORY

ARBUTUS MEM. PK.

23d. LOCATION

BALTIMORE

24. FUNERAL DIRECTOR

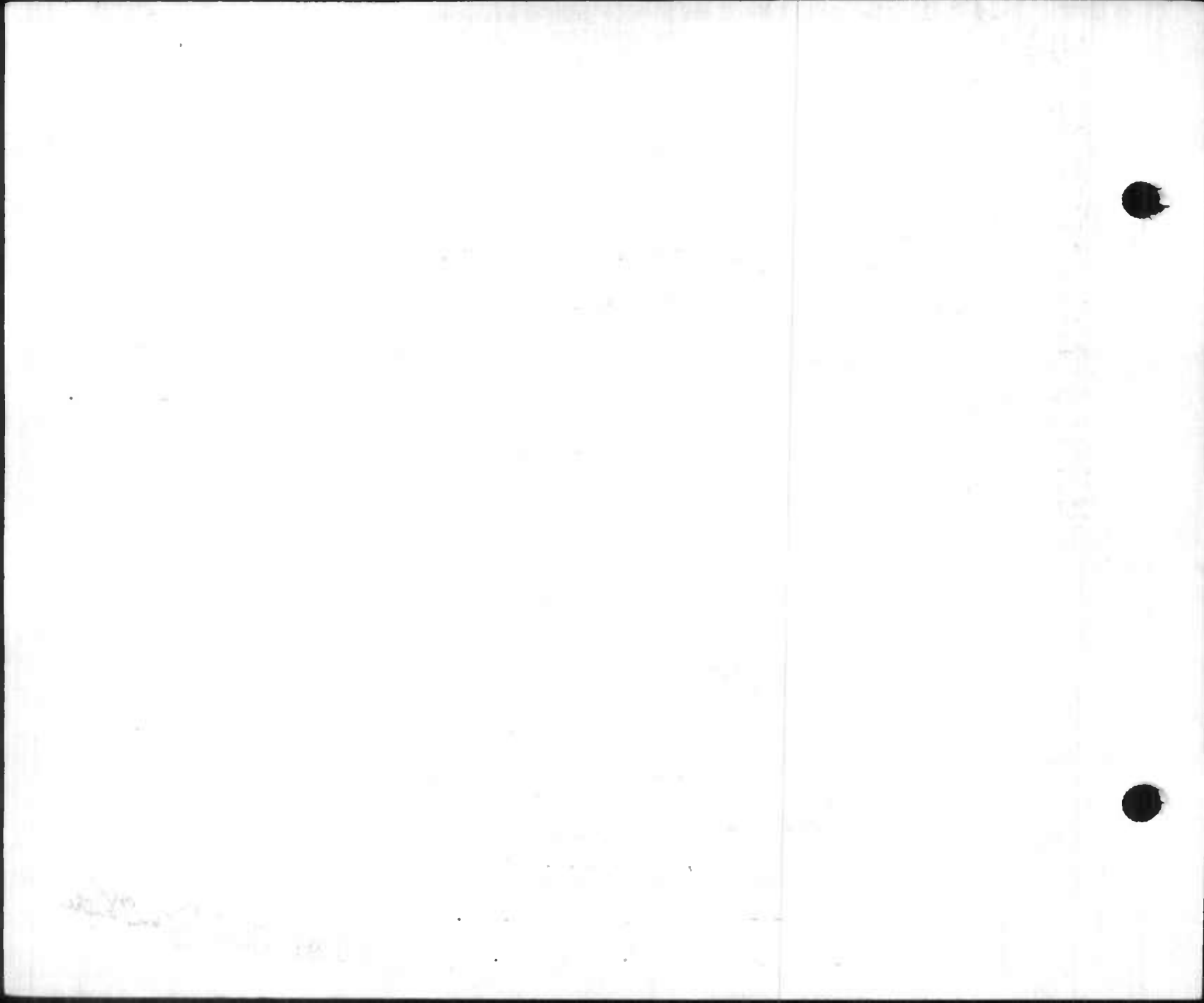
ELIZABETH L. PHILLIPS 1721 N. MONROE ST.

25a. DATE REC'D. BY REGISTRAR

FEB 10 1982

25b. DATE REC'D. BY REGISTRAR

Charles J. Phillips



DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 2 0 3 9 6 7

FOR
1. STATE
REGISTRAR

REG. NO.

| | | | | | | | | | | | |
|---|--|-------------------------|---|---|---|---|--|--|---|--|--|
| 1. DECEASED NAME
(TYPE OR PRINT) Clarence L. LITZ | | | 2a. DATE OF DEATH
MONTH 2 DAY 9 YEAR 82 | | | 2b. HOUR
10⁵³A | | | | | |
| 3. SEX
MALE | | 4. RACE
White | | 5. DATE OF BIRTH
MONTH 7 DAY 21 YEAR 03 | | 6. AGE (IN YEARS LAST BIRTHDAY)
78 YRS. | | 7. IF UNDER 1 YEAR
MONTHS 0 DAYS 0 | | 8. IF UNDER 24 HRS
HOURS 0 MIN. 0 | |
| 9. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
Maryland | | | 7b. CITIZEN OF WHAT COUNTRY?
U.S.A. | | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | | 9. BALTIMORE CITY OR COUNTY OF DEATH
Baltimore City MD. | | |
| 10. CITY OR TOWN OF DEATH
Baltimore | | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
South Baltimore General Hosp. | | | 12a. USUAL OCCUPATION
(TYPE OF WORK - "MOS" OR WORKING LIFE)
Electrician | | | 12b. KIND OF BUSINESS OR INDUSTRY
Revere | | |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)
13a. STATE MD. 13b. COUNTY MAA 13c. CITY OR TOWN Baltimore | | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | 13e. STREET ADDRESS
308 Orchard Ave., 21225 | | | | | |
| 14. FATHER'S NAME
FIRST Joseph MIDDLE H. LAST Litz | | | 15. MOTHER'S MAIDEN NAME
FIRST Catherine MIDDLE Waltz LAST Waltz | | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(OR UNKNOWN) (IF YES, GIVE WAR OR DATES)
Yes WWII | | | 16b. SOCIAL SECURITY NO.
216-10-8238 | | | 17. INFORMANT
Sophia Litz (same as 13e) | | | ADDRESS | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART 1. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Acute Myocardial Infarction
4100
DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b) Hypertensive Atherosclerotic
DUE TO, OR AS A CONSEQUENCE OF
cardiovascular disease
(c) | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
few minutes | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | | | |
| 21d. INJURY OCCURRED
WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 5/1 , 19 80 , to 2/9 , 19 82 , that (I) (we) last saw the deceased alive on 1/12 , 19 82 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | | | |
| 22b. SIGNATURE
S. Mundra | | | DEGREE
MD | | | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | | 22c. DATE SIGNED
2/9/82 | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
SURYA P. MUNDRA | | | 22e. ADDRESS
203 E Patapsco Ave Balt MD 21225 | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)
Burial | | | 23b. DATE
2/12/1982 | | 23c. NAME OF CEMETERY OR CREMATORY
Meadowridge Memorial | | | 23d. LOCATION
CITY OR TOWN Baltimore, Md. COUNTY STATE | | | |
| 24. FUNERAL DIRECTOR
NAME Balto. Md. 21225
George J. Gonce F.H. 4001 Ritchie Hwy. | | | | | | 25a. DATE REC'D. BY REGISTRAR
FEB 11 1982 | | 25b. REGISTRAR'S SIGNATURE
James J. [Signature] | | | |

BP

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 4 and 5 must be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

11/11/11

414

5704

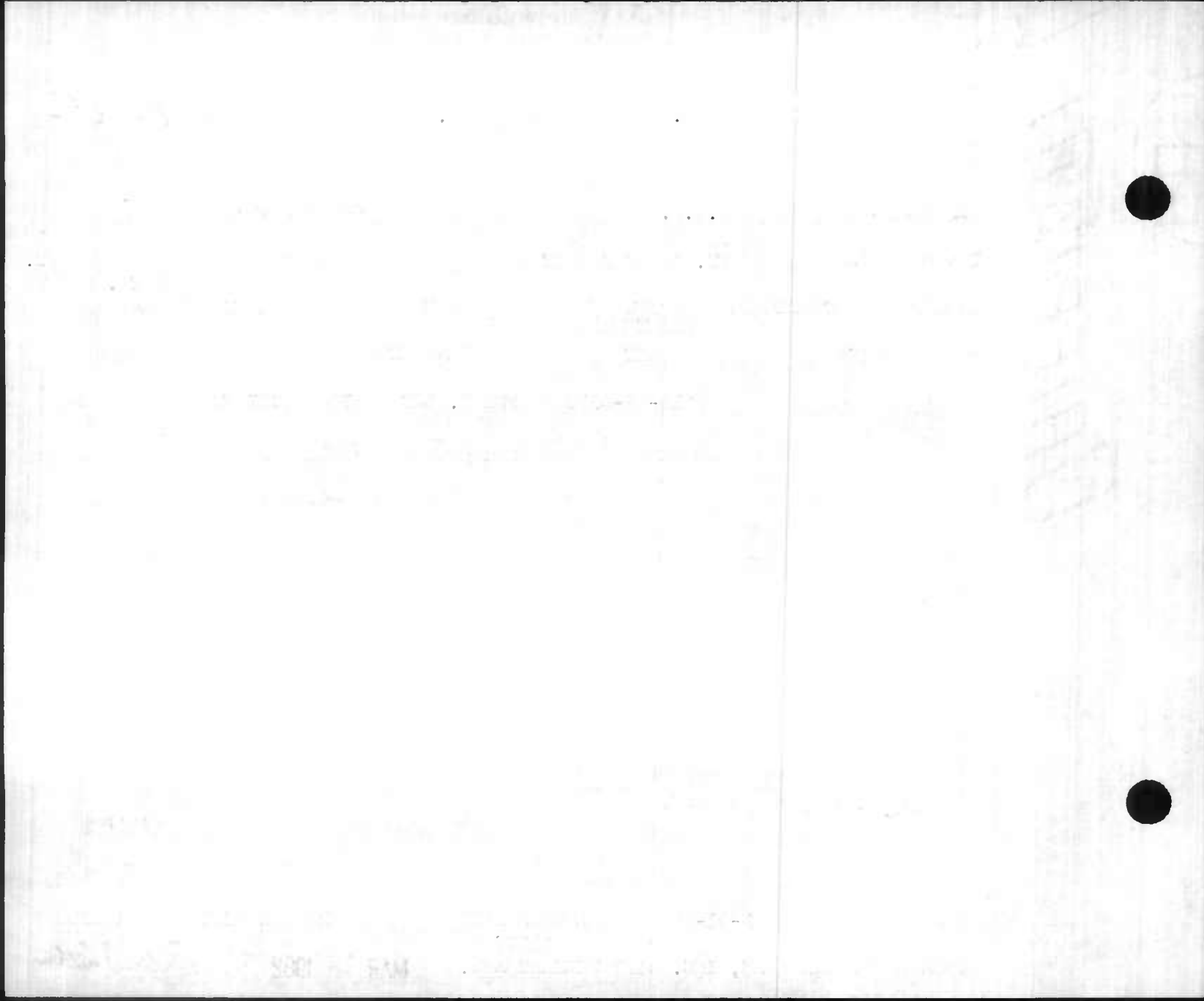
1944-1945

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed - then 72 hours with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified and a post-mortem examination must be made.1 - FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | | |
|--|---|---|--|--|---|--|--|--|
| 1. DECEASED NAME
(TYPE OR PRINT) | | | 2a. DATE OF DEATH | | | 2b. HOUR | | |
| WILLIAM E. LITZ SR. | | | 2-26-82 | | | 6:50 AM | | |
| 3. SEX | 4. RACE | 5. DATE OF BIRTH | 6. AGE (IN YEARS LAST BIRTHDAY) | | | IF UNDER 1 YEAR | | |
| MALE | WHITE | 05 15 12 | 69 YRS. | | | MONTHS DAYS HOURS MIN. | | |
| 7a. BIRTHPLACE
(STATE OR FOREIGN COUNTRY) | 7b. CITIZEN OF WHAT COUNTRY? | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 9. BALTIMORE CITY OR COUNTY OF DEATH | | | | | |
| MARYLAND | U.S.A. | | BALTIMORE CITY MD. | | | | | |
| 10. CITY OR TOWN OF DEATH | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE) | | | 12b. KIND OF BUSINESS OR INDUSTRY | | |
| BALTO, MD | ST. AGNES HOSPITAL | | FOREMAN | | | HIGHWAY DEPT. | | |
| 13a. STATE | 13b. CITY OR TOWN | 13c. INSIDE CITY LIMITS? | 13d. STREET ADDRESS | | | 13e. BALTO. COUNTY | | |
| MARYLAND | BALTIMORE | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | 4700 WASHINGTON BOULEVARD | | | | | |
| 14. FATHER'S NAME | 15. MOTHER'S MAIDEN NAME | | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? | | | 16b. SOCIAL SECURITY NO. | | |
| FREDERICK LITZ | HENRIETTA LINK | | NO | | | 212-22-4578 | | |
| 17. INFORMANT | | | ADDRESS | | | 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) | | |
| ANNA M. LITZ | | | 4700 WASHINGTON BOULEVARD | | | PART 1. DEATH WAS CAUSED BY: | | |
| | | | | | | IMMEDIATE CAUSE (a) <u>Cardiorespiratory Arrest</u> | | |
| | | | | | | DUE TO, OR AS A CONSEQUENCE OF | | |
| | | | | | | (b) <u>Possible Myocardial Infarct</u> | | |
| | | | | | | DUE TO, OR AS A CONSEQUENCE OF | | |
| | | | | | | (c) _____ | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a | | | | | | | | |
| 19a. DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY? | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? |
| | | | | | | YES <input type="checkbox"/> NO <input type="checkbox"/> | | YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) | | | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/> | | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>2-21</u> 19 <u>82</u> , to <u>2-26</u> 19 <u>82</u> , that (I) (we) last saw the deceased alive on <u>2-26</u> 19 <u>82</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | 22b. SIGNATURE
<u>Ricardo L. Machado</u> | | | DEGREE
ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> PHYSICIAN <input checked="" type="checkbox"/> | | 22c. DATE SIGNED
2/26/82 |
| 23a. PHYSICIAN'S NAME (TYPE OR PRINT) | | | 23b. ADDRESS | | | 23c. DATE REC'D. BY REGISTRAR | | |
| RICARDO L. MACHADO, M.D. | | | St Agnes Hospital BALTO. MD. | | | 23d. REGISTRAR'S SIGNATURE
<u>James VanNathan</u> | | |
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY) | | | 23b. DATE | | 23c. NAME OF CEMETERY OR CREMATORY | | 23d. LOCATION
CITY OR TOWN COUNTY STATE | |
| BURIAL | | | 03-01-82 | | LOUDON PARK | | BALTIMORE CITY MARYLAND | |
| 24. FUNERAL DIRECTOR
NAME | | | 24b. ADDRESS | | | 25a. DATE REC'D. BY REGISTRAR | | |
| HUBBARD FUNERAL HOME, INC. | | | 4107 WILKENS AVE. | | | MAR 1 1982 | | |



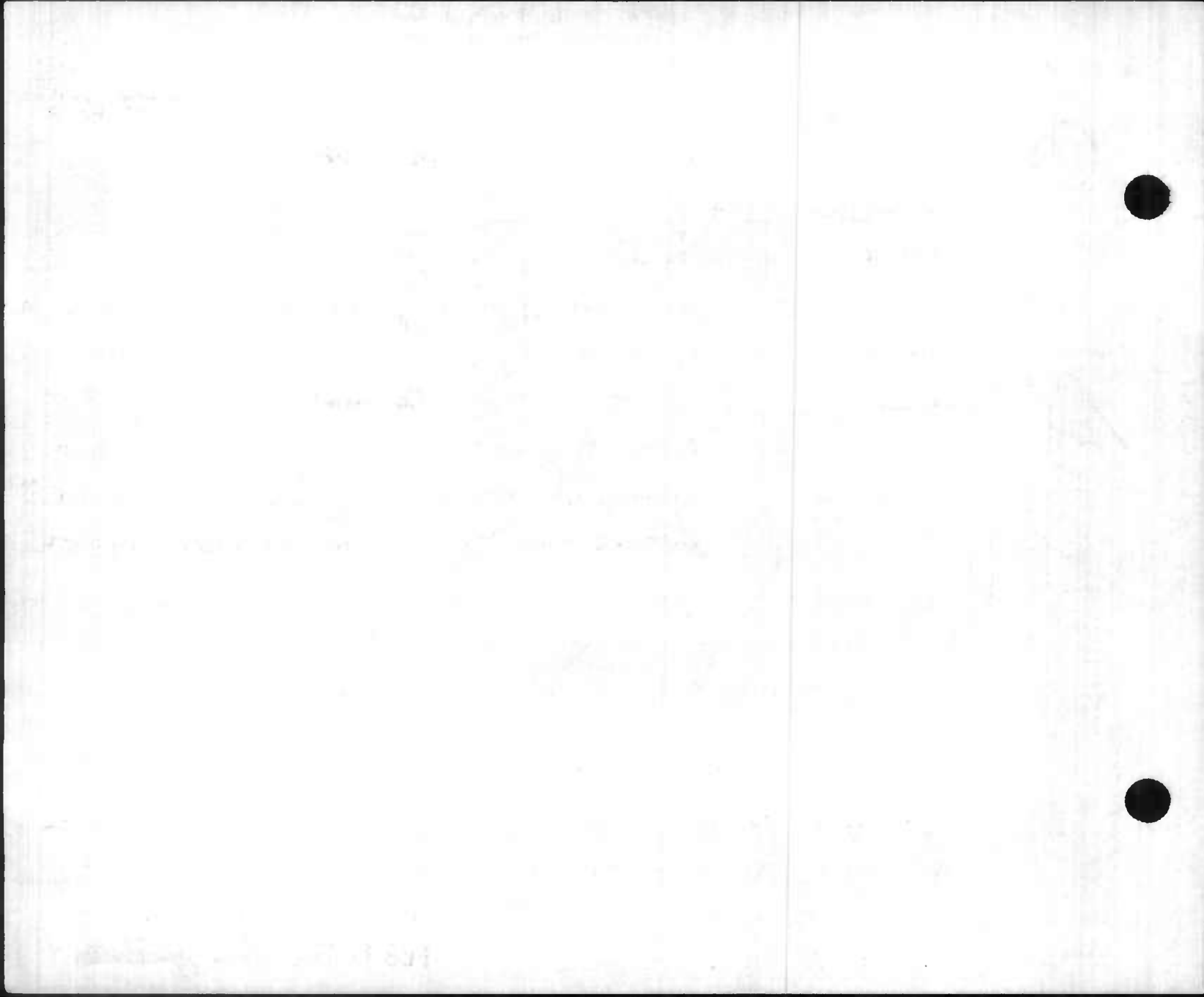
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified and a medical certification completed.

MEDICAL CERTIFICATION

| STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH | | | | | | | | | |
|--|--|---|--|--|--|---|--|---|--|
| 1 - FOR STATE REGISTRAR | | 8 2 0 3 9 6 9 | | | | REG. NO. | | | |
| 1 DECEASED NAME (TYPE OR PRINT)
LIVINGSTON DAVID NMI LIVINGSTON | | | | | | 2a DATE OF DEATH
MONTH DAY YEAR
2 7 82 | | 2b HOUR
10 ⁵⁰ P M | |
| 3 SEX
MALE | | 4 RACE
BLACK | | 5 DATE OF BIRTH
MONTH DAY YEAR
12 25 15 | | 6 AGE (IN YEARS LAST BIRTHDAY)
66 YRS. | | IF UNDER 1 YEAR
MONTHS DAYS
IF UNDER 24 HRS
HOURS MIN. | |
| 7a BIRTHPLACE (STATE OR FOREIGN COUNTRY)
SOUTH CAROLINA | | 7b CITIZEN OF WHAT COUNTRY?
USA | | 8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
BALTIMORE CITY MD. | | | |
| 10 CITY OR TOWN OF DEATH
BALTIMORE | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
UNIVERSITY OF MD. HOSPITAL | | | | 12a USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
RETIRED | | 12b KIND OF BUSINESS OR INDUSTRY | |
| 13a USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)
13a. STATE MD. 13b. COUNTY - 13c. CITY OR TOWN BALTIMORE | | | | | | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS
DEATON CENTER/630 E. CHARLES ST. | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
HENRY NMI LIVINGSTON | | | | 15 MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
ADDIE NMI BROWN | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
UNKNOWN | | 16b. SOCIAL SECURITY NO.
(IF YES, GIVE WAR OR DATES)
251-03-7037 | | 17 INFORMANT ADDRESS
Alice Livingston 2000 Odell Avenue | | | | | |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART 1 DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>CARDIO-PULMONARY ARREST</u>
4411
DUE TO, OR AS A CONSEQUENCE OF
(b) <u>EXSANGUINATION</u>
DUE TO, OR AS A CONSEQUENCE OF
(c) <u>RUPTURED SACCULAR THORACIC ANEURYSM</u> | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
IMMEDIATE
IMMEDIATE
IMMEDIATE | |
| PART 2 OTHER SIGNIFICANT CONDITIONS <u>CONTRIBUTING TO DEATH</u> BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 | | | | | | | | | |
| 19a DATE OF OPERATION | | 19b CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | | | |
| 21d INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK AT WORK | | 21e PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f LOCATION
STREET CITY OR TOWN COUNTY STATE | | | | | |
| 22a I certify that (I) (this hospital) attended the deceased from <u>2-1</u> , 19 <u>82</u> , to <u>2-7</u> , 19 <u>82</u> , that (I) (we) lost
saw the deceased alive on <u>2-4</u> , 19 <u>82</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated
above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | |
| 22b SIGNATURE
Lauren A. Schnaper MD | | | | DEGREE
ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> | | | | 22c. DATE SIGNED
2-7-82 | |
| 22d PHYSICIAN'S NAME (TYPE OR PRINT)
LAUREN A. SCHNAPER MD | | | | 22e ADDRESS
UNIV. OF MD. HOSPITAL 22 S. GREEN ST. | | | | | |
| 23a BURIAL, CREMATION, REMOVAL
(TYPE)
Burial | | 23b DATE
2/13/82 | | 23c NAME OF CEMETERY OR CREMATORY
Cedar Hill Cem. | | 23d LOCATION
CITY OR TOWN COUNTY STATE
Baltimore Co. MD | | | |
| 24 FUNERAL DIRECTOR
NAME ADDRESS
Wm. C. March F/H 1101 E. North Avenue | | | | 25a. DATE REC'D. BY REGISTRAR REGISTRAR'S SIGNATURE
FEB 10 1982 | | | | | |

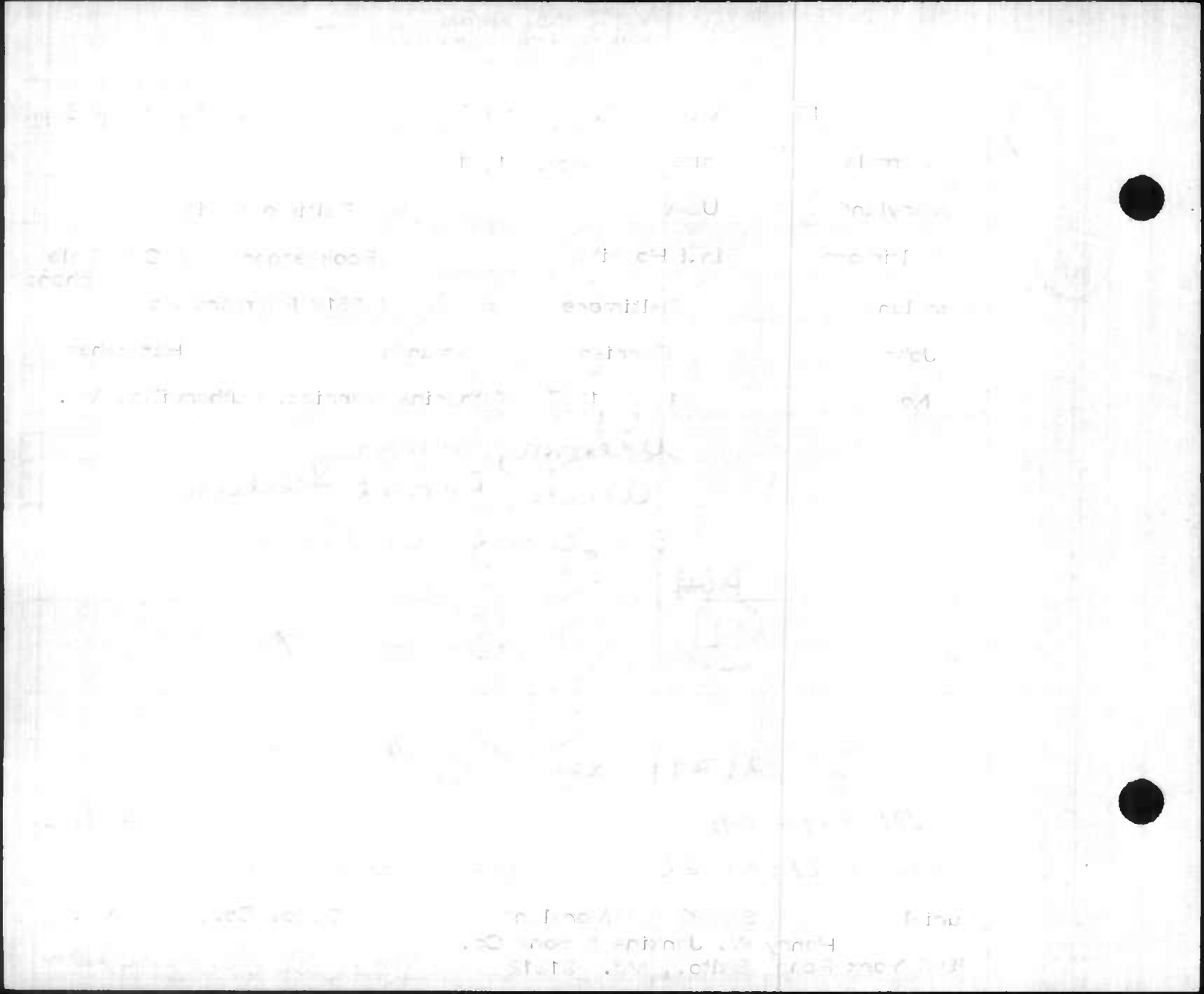


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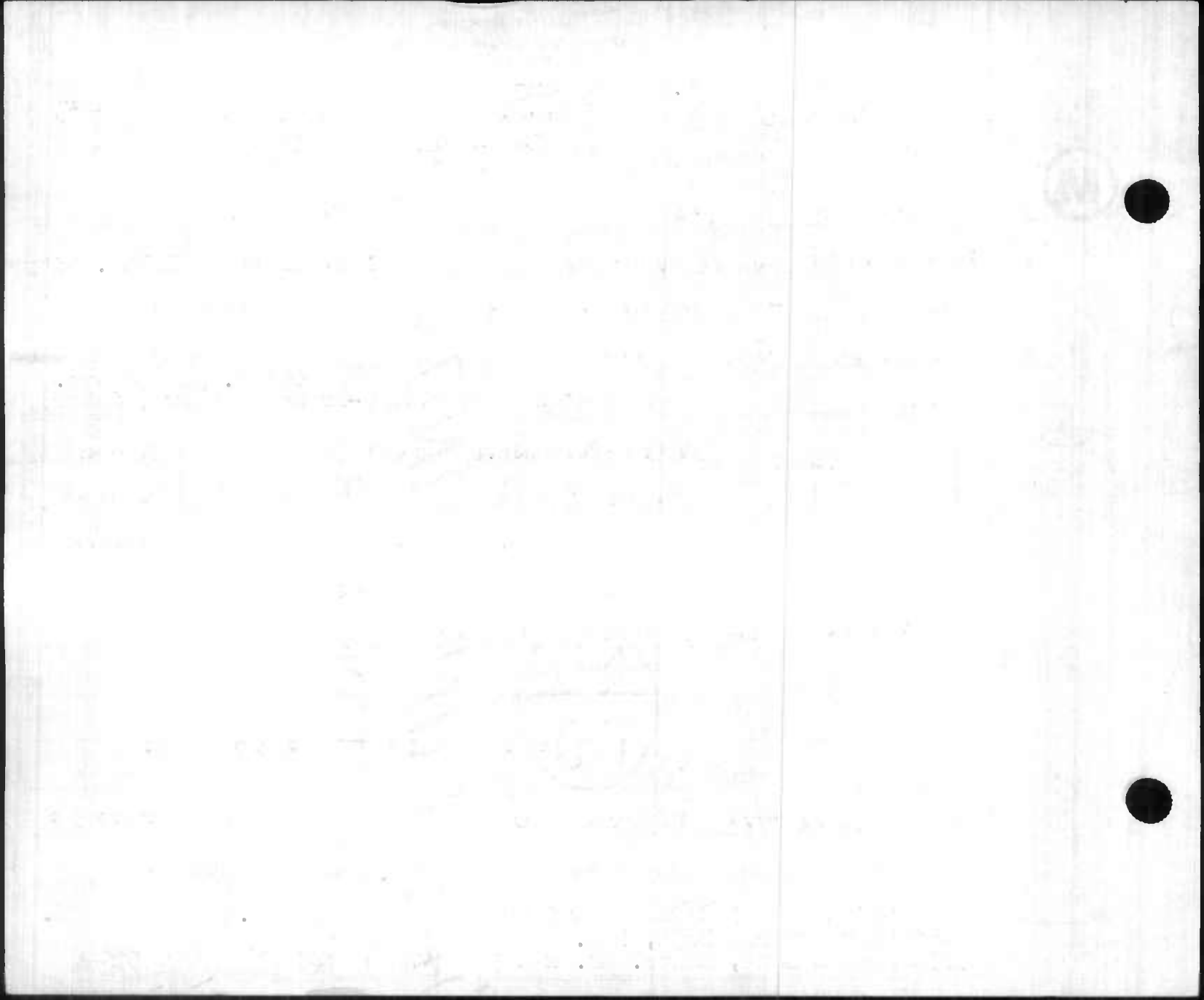
| STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH | | | | | | | | | | REG. NO.
82 03970 | |
|---|--|--|--|--|--|--|--|--|--|---|--|
| 1. FOR STATE REGISTRAR | | | | | | | | | | | |
| 1. DECEASED NAME
(Type or Print) FIRST MIDDLE LAST
ALICE M. P. LOHR | | | | | | | | | | 2a. DATE OF DEATH
MONTH DAY YEAR
2 27 82 | |
| 3. SEX
Female | | | | | | | | | | 2b. HOUR
10:30 P.M. | |
| 4. RACE
White | | | | | | | | | | 6. AGE (IN YEARS LAST BIRTHDAY)
95 YRS | |
| 5. DATE OF BIRTH
MONTH DAY YEAR
Oct. 21, 1886 | | | | | | | | | | IF UNDER 1 YEAR
MONTHS DAYS HOURS MIN. | |
| 7a. BIRTHPLACE
(State or Foreign Country)
Maryland | | | | | | | | | | 7b. CITIZEN OF WHAT COUNTRY?
USA | |
| 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/> | | | | | | | | | | 9. BALTIMORE CITY OR COUNTY OF DEATH
Baltimore City MD. | |
| 10. CITY OR TOWN OF DEATH
Baltimore | | | | | | | | | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(If not in such facility, give street address)
Sinai Hospital | |
| 12a. USUAL OCCUPATION
(Type of work for most of working life)
Bookkeeper | | | | | | | | | | 12b. KIND OF BUSINESS OR INDUSTRY
C&P Telephone | |
| 13a. USUAL RESIDENCE (If nursing home or other institution, give residence before admission)
13a. STATE
Maryland | | | | | | | | | | 13b. COUNTY
— | |
| 13c. CITY OR TOWN
Baltimore | | | | | | | | | | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 13e. STREET ADDRESS
3618 Rexmere Road | | | | | | | | | | | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
John Parrish | | | | | | | | | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
Amanda Hampsher | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
No | | | | | | | | | | 16b. SOCIAL SECURITY NO.
(IF YES, GIVE WAR OR DATES)
212 05 1382 | |
| 17. INFORMANT
ADDRESS
Katherine Merrick, Lutherville, Md. | | | | | | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART 1. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>Uremia, Sepsis</u>
5609
DUE TO, OR AS A CONSEQUENCE OF
(b) <u>Acute Renal Failure</u>
DUE TO, OR AS A CONSEQUENCE OF
(c) <u>Intestinal Obstruction</u>
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a):
<u>AGE</u> | | | | | | | | | | APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATH | |
| 19a. DATE OF OPERATION | | | | | | | | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | |
| 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | | | | | | 20b. IF YES, WERE FINDINGS USED
IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | | | | | | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | |
| 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) | | | | | | | | | | | |
| 21d. INJURY OCCURRED
WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | | | | | | | | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | |
| 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | | | | | | | | | |
| 22a. I certify that (this hospital) attended the deceased from <u>1/11</u> 19 <u>82</u> to <u>2/27</u> 19 <u>82</u> , that (we) lost
saw the deceased alive on <u>2/27</u> 19 <u>82</u> , and that in my (our) opinion death occurred on the date and hour and from the causes stated
above (If (we) did not view the body after death). | | | | | | | | | | 22b. SIGNATURE
<u>Sheila Ebenezer MD</u>
DEGREE
ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> | |
| 22c. DATE SIGNED
<u>2/27/82</u> | | | | | | | | | | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
<u>SHEILA EBENEZER</u> | | | | | | | | | | 22e. ADDRESS
<u>SINAI HOSPITAL, BALTO. MD</u> | |
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)
Burial | | | | | | | | | | 23b. DATE
3/3/82 | |
| 23c. NAME OF CEMETERY OR CREMATORY
Moreland | | | | | | | | | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
Balto. Co., Md. | |
| 24. FUNERAL DIRECTOR
NAME
Henry W. Jenkins & Sons Co.
ADDRESS
4905 York Road Balto., Md. 21212 | | | | | | | | | | 25a. DATE REC'D. BY REGISTRAR
MAR 1 1982 | |
| 25b. REGISTRAR'S SIGNATURE
<u>Frances Jan Nathan</u> | | | | | | | | | | | |



TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death and may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

| STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH | | | | | | | | | | REG. NO.
8 2 0 3 9 7 1 | |
|---|--|---|--|---|--|---|--|--|--|---|--|
| 1. DECEASED NAME
(TYPE OR PRINT)
Charles E. Long | | 2a. DATE OF DEATH
MONTH DAY YEAR
2-27-82 | | 2b. HOUR
5:20 P M | | 3. SEX
MALE | | 4. RACE
CAUCASIAN | | 5. DATE OF BIRTH
MONTH DAY YEAR
1-14-1912 | |
| 7a. BIRTHPLACE
(STATE OR FOREIGN COUNTRY)
USA - MD. | | 7b. CITIZEN OF WHAT COUNTRY?
USA | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
BALTIMORE CITY MD. | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
LampLighter | | 12b. KIND OF BUSINESS OR INDUSTRY
Balto. City | |
| 10. CITY OR TOWN OF DEATH
BALTIMORE, MD. | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
UNIV. OF MD. HOSPITAL | | 13a. STATE
MD. | | 13b. COUNTY
- | | 13c. CITY OR TOWN
BALTIMORE | | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
CHARLES NMI LONG | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
ANNA VINNINGER | | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO, UNKNOWN)
NO | | 16b. SOCIAL SECURITY NO.
212-12-9352 | | 17. INFORMANT
ADDRESS
611 N. Decker Ave.
PT. CHART-Irene Pletzer (sister) | | | |
| 18. CAUSE OF DEATH: Enter only one cause per line for (a), (b), and (c).
PART 1: DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) CARDIO-PULMONARY ARREST
4476
DUE TO, OR AS A CONSEQUENCE OF
(b) SEPTIC SHOCK
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(c) MULTIPLE ORGAN FAILURE | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
20 MINS.
30 MINS.
1 WEEK | |
| PART 2: OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (d)
PNEUMONIA, PERIPHERAL VASCULAR DISEASE | | | | | | | | | | | |
| 19a. DATE OF OPERATION
2-8-82 | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED
LEFT ILIAC ENDARTERECTOMY | | | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | | | | | |
| 21d. INJURY OCCURRED
WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 2-27 19 82 to 2-27 19 82 , that (I) (we) lost saw the deceased alive on 2-27 19 82 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | | | |
| 22b. SIGNATURE
Lauren Ann Schnaper MD | | | | | | | | DEGREE
MD | | 22c. DATE SIGNED
2-27-82 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
LAUREN ANN SCHNAPER | | | | | | | | 22e. ADDRESS
UNIVERSITY OF MARYLAND HOSPITAL | | | |
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)
Burial | | 23b. DATE
3/2/82 | | 23c. NAME OF CEMETERY OR CREMATORY
Baltimore Cemetery | | 23d. LOCATION
CITY OR TOWN COUNTY
Balto. Md. | | | | | |
| 24. Schimunek Funeral Home, Inc.
3331 Brehms Lane, Balto. Md. 21213 | | | | | | 25a. DATE REC'D. BY REGISTRAR
MAR 1 1982 | | 25b. REGISTRAR'S SIGNATURE
James J. [Signature] | | | |



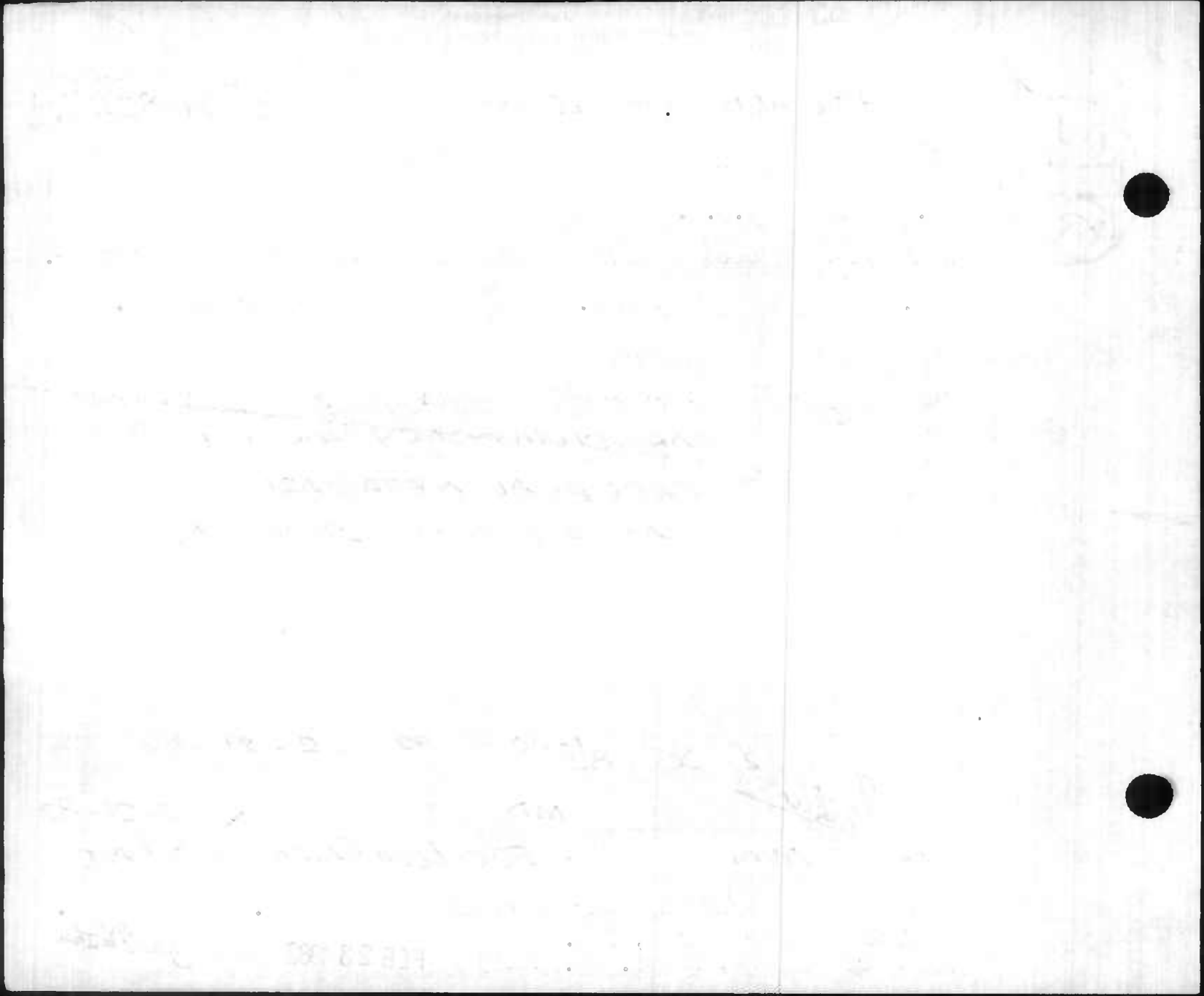
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified by phone.

MEDICAL CERTIFICATION

| STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH | | | | 8 2 0 3 9 7 2 | | | |
|---|--|---|--|---|--|---|--|
| 1. FOR STATE REGISTRAR | | | | REG. NO. | | | |
| 1. DECEASED NAME (TYPE OR PRINT) Edward V. LONG | | | | 2a. DATE OF DEATH 2-21-82 12:30 | | | |
| 3 SEX Male | | 4. RACE White | | 5. DATE OF BIRTH August 21 1920 | | 6. AGE (IN YEARS LAST BIRTHDAY) 61 YRS. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Md. | | 7b. CITIZEN OF WHAT COUNTRY? U.S.A. | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City MD | |
| 10. CITY OR TOWN OF DEATH Baltimore | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Good Samaritan Hospital | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Accountant | | 12b. KIND OF BUSINESS OR INDUSTRY Martin Co. | |
| 13a. STATE Md. | | 13b. COUNTY Balto. | | 13c. CITY OR TOWN Balto. | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 14. FATHER'S NAME John Long | | 15. MOTHER'S MAIDEN NAME Frances Payne | | 13e. STREET ADDRESS 4003 Ardley Ave. | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) Yes | | 16b. SOCIAL SECURITY NO. 214-12-8669 | | 17. INFORMANT Frances Long (wife) same address | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CARDIOPULMONARY ARREST | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | | |
| 1629 } DUE TO, OR AS A CONSEQUENCE OF (b) CEREBRAL METASTASIS | | | | | | | |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO, OR AS A CONSEQUENCE OF (c) OAT CELL LUNG CARCINOMA | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | |
| 22a. I certify that (I) (his hospital) attended the deceased from 1-30-82 to 2-21-82 , that (I) (we) last saw the deceased alive on 2-20-82 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | |
| 22b. SIGNATURE [Signature] | | | | DEGREE MD ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> | | 22c. DATE SIGNED 2-21-82 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) DR. Z. MIN. | | | | 22e. ADDRESS 5601 LOCH RAVEN BLVD, BALT. | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | | 23b. DATE 2/25/82 | | 23c. NAME OF CEMETERY OR CREMATORY Holy Redeemer | | 23d. LOCATION CITY OR TOWN COUNTY STATE Balto. Md. | |
| 24. FUNERAL DIRECTOR Schrimunek Funeral Home, Inc. 3331 Brehms Lane, Balto. Md. 21213 | | | | 25a. DATE REC'D. BY REGISTRAR FEB 23 1982 25b. REGISTRAR'S SIGNATURE [Signature] | | | |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed - this is with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP

DHMH-16 50M 1/81
(VRA 15, 4)

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 2 0 3 9 7 3

REG. NO.

| | | | | | | | |
|---|--|--|--|---|--|---|--|
| 1. FOR
STATE
REGISTRAR | | 1. DECEASED NAME
(TYPE OR PRINT) FIRST MIDDLE LAST
LILLIE MAE LOVERN | | 2a. DATE OF DEATH MONTH DAY YEAR
2-10-82 | | 2b. HOUR
2:55 P.M. | |
| 3. SEX
FEMALE | | 4. RACE
Caucasian | | 5. DATE OF BIRTH MONTH DAY YEAR
5 3 98 | | 6. AGE (IN YEARS LAST BIRTHDAY) YRS MONTHS DAYS
84 | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
SOUTH CAROLINA | | 7b. CITIZEN OF WHAT COUNTRY?
USA | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
BALTIMORE CITY MD | |
| 10. CITY OR TOWN OF DEATH
BALTIMORE | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
DEATON Medical Center | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)
Housewife | | 12b. KIND OF BUSINESS OR INDUSTRY
Home | |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE 13b. COUNTY
MARYLAND HARFORD | | 13c. CITY OR TOWN
EDGEWOOD | | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 13e. STREET ADDRESS
402 LIBERTY CT. | |
| 14. FATHER'S NAME FIRST MIDDLE LAST
ODIS GREENLEAF ELLISON | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST
MAGGIE M COOPER | | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO | | 16b. SOCIAL SECURITY NO.
238-42-7296 | |
| 17. INFORMANT
Mrs. Eugene Robinson Edgewood, Maryland | | 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART 1. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) RESPIRATORY ARREST
4860
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last:
DUE TO, OR AS A CONSEQUENCE OF (b) PNEUMONIA
DUE TO, OR AS A CONSEQUENCE OF (c) | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)
CONGESTIVE HEART FAILURE | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR
19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from AUG. 6 19 81 to FEB. 10 19 82 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | |
| 22b. SIGNATURE
Wm. H. Davis | | DEGREE MD | | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | 22c. DATE SIGNED
2/10/82 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
DAVIS | | 22e. ADDRESS
J.L. DEATON, 611 CHARLES ST., BALT. MD. | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)
REMOVAL | | 23b. DATE
Feb. 10, '82 | | 23c. NAME OF CEMETERY OR CREMATORY
Wolfe Funeral Home | | 23d. LOCATION CITY OR TOWN COUNTY STATE
Fort Mill York South Carolina | |
| 24. FUNERAL DIRECTOR NAME
Howard K. McComas III | | ADDRESS
Abingdon, Maryland | | 25a. DATE REC'D. BY REGISTRAR
FEB 16 1982 | | 25b. REGISTRAR
Charles | |

page 3
death

100-100-100

100-100-100

100-100-100

100-100-100

100-100-100

100-100-100

100-100-100

100-100-100

100-100-100

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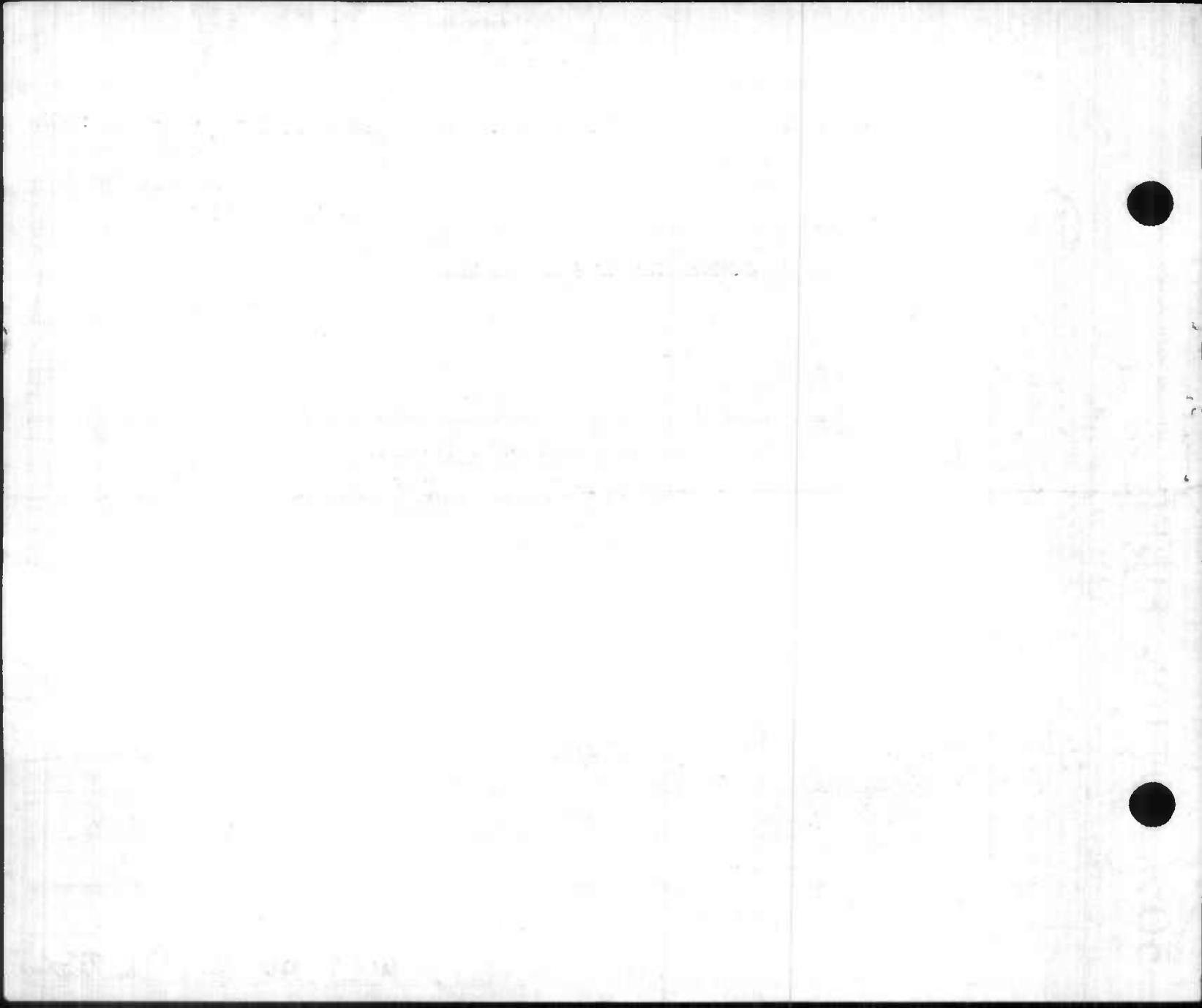
STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 2 0 3 9 7 4

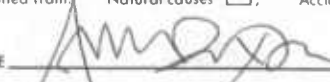

FOR
1. STATE
REGISTRAR

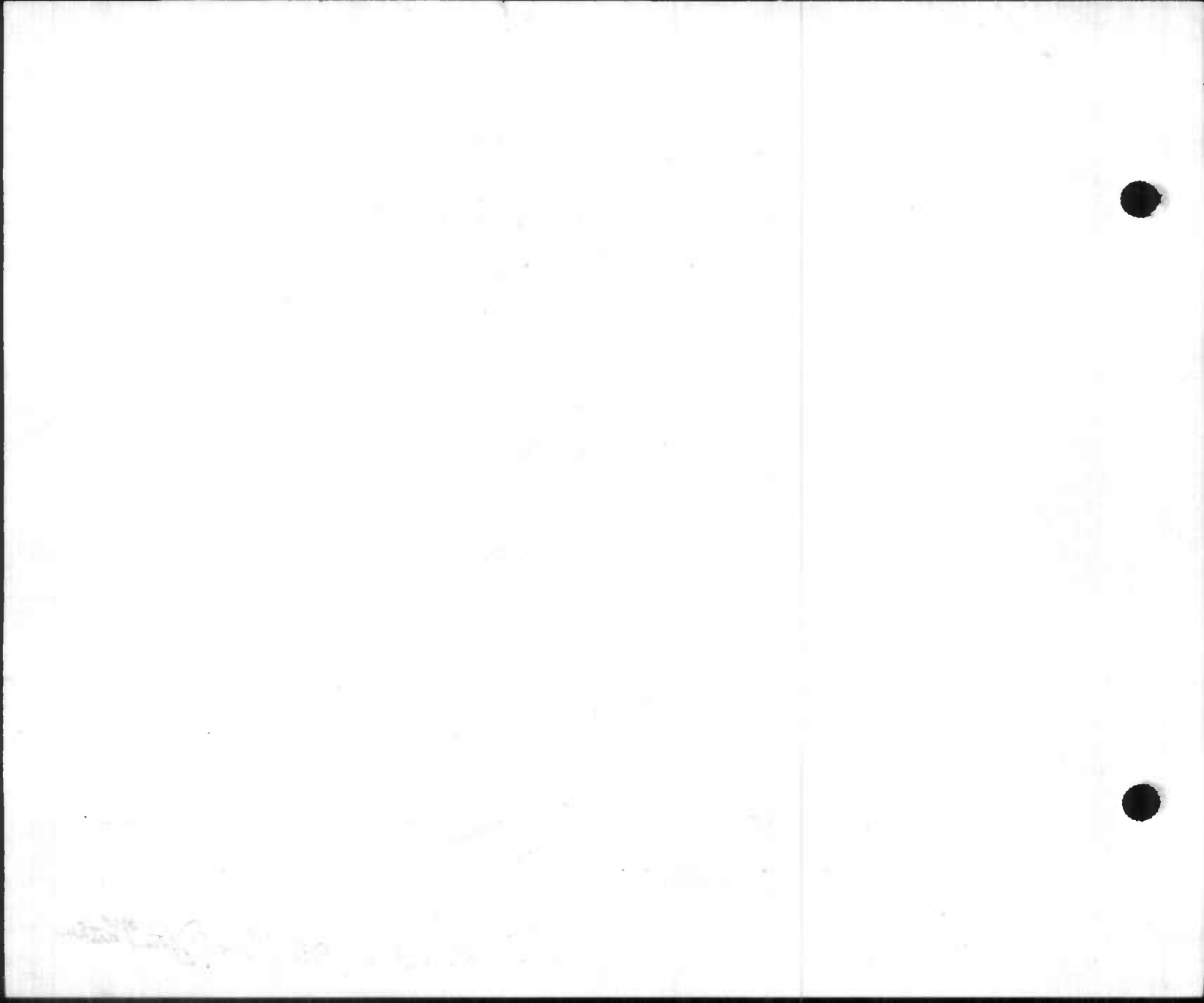
REG. NO.

| | | | | | | | |
|---|--|---|---|---|--|--|--|
| 1. DECEASED NAME
(TYPE OR PRINT)
JOSEPH A. LOWE (JR.) | | | 2a. DATE OF DEATH
MONTH DAY YEAR
FEBRUARY 26, 1982 | | | 2b. HOUR
7:00AM | |
| 3. SEX
Male | | 4. RACE
Black | | 5. DATE OF BIRTH
MONTH DAY YEAR
6 24 63 | | 6. AGE (IN YEARS LAST BIRTHDAY)
18 YRS. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
Md. | | 7b. CITIZEN OF WHAT COUNTRY?
USA | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
BALTIMORE CITY MD. | |
| 10. CITY OR TOWN OF DEATH
Balto. | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
JOHNS HOPKINS HOSPITAL | | | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE) | |
| 13a. STATE
Md. | | 13b. COUNTY | | 13c. CITY OR TOWN
Balto. | | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
Bernard Lowe | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
Phyllis Della | | 16. SOCIAL SECURITY NO.
214-88-9478 | | | |
| 17. INFORMANT
Phyllis Lowe | | 18. ADDRESS
105 N. Wolfe St. | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 2/22/82 , 19 82 , to 2/26/82 , 19 82 that (I) (we) lost
saw the deceased alive on 2/26/82 , 19 82 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated
above, (I) (we) (did) (did not) view the body after death. | | | | | | | |
| 22b. SIGNATURE
<i>Phyllis</i> | | DEGREE
HBCH BSc
ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> | | | | 22c. DATE SIGNED
2/26/82 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
MILNER | | 22e. ADDRESS
JOHNS HOPKINS HOSPITAL | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)
Burial | | 23b. DATE
3/3/82 | | 23c. NAME OF CEMETERY OR CREMATORY
Mt. Calvary Cem. | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
Anne Arundel Co., Md. | |
| 24. FUNERAL DIRECTOR
NAME
Wm C March F/H | | ADDRESS
1101 E. North Ave. | | 25a. DATE REC'D. BY REGISTRAR
MAR 1 1982 | | 25b. REGISTRAR'S SIGNATURE
<i>James J. Warren</i> | |



TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE MEDICAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM FM 3. RETAIN PAGE 5 WITH YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

| STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH | | | | | | | | | | | | REG. NO. 8 2 0 3 9 7 5 | |
|--|--|-------------------------|--|---|--|---|--|---|--|---|--|---|--|
| 1. DECEASED NAME
(TYPE OR PRINT) FIRST MIDDLE LAST
JACK LOWERY | | | | | | 2a. DATE KNOWN OF DEATH <input checked="" type="checkbox"/> MATED <input type="checkbox"/> MONTH DAY YEAR
2 6 19 82 | | | | 2b. HOUR
M | | | |
| 3. SEX
male | | 4. RACE
negro | | 5. DATE OF BIRTH
MONTH DAY YEAR
6 14 1914 | | 6. AGE (IN YEARS)
LAST BIRTHDAY YRS.
67 | | IF UNDER 1 YR. MONTHS DAYS
67 | | IF UNDER 24 HRS. HOURS MIN.
67 | | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
S. C. | | | | 7b. CITIZEN OF WHAT COUNTRY?
USA | | | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | | | | |
| 7c. DATE PRONOUNCED DEAD
2 6 19 82 | | | | 9. BALTIMORE CITY OR COUNTY OF DEATH
Baltimore City MD. | | | | | | | | | |
| 10. CITY OR TOWN OF DEATH
Baltimore | | | | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
900 blk. Ashburton St. | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | | | | 12b. KIND OF BUSINESS OR INDUSTRY | |
| 13a. STATE
Md | | 13b. COUNTY | | 13c. CITY OR TOWN
Baltimore | | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS
1006 N. Ashburton Street | | | | | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
Tom Lowery | | | | | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
Carrie Gibbs | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO, OR UNKNOWN) (IF YES, GIVE WAR OR DATES)
No | | | | 16b. SOCIAL SECURITY NO. | | 17. INFORMANT ADDRESS
Helena Lowery 1006 N. Ashburton Street | | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Gunshot wound of abdomen (handgun)
9650
Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last:
(b) _____
(c) _____
DUE TO, OR AS A CONSEQUENCE OF
DUE TO, OR AS A CONSEQUENCE OF
DUE TO, OR AS A CONSEQUENCE OF | | | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a). | | | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | | | | | | | | 20. AUTOPSY?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH | | | | 21b. TIME OF INJURY
HOUR MIN. MONTH DAY YEAR
P.M. 2-6- 1982 | | | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)
Subject was shot. | | | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK | | | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)
street | | | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE
900 blk. Ashburton St., Balto. Md. | | | | | |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input checked="" type="checkbox"/> Undetermined manner <input type="checkbox"/> . | | | | | | | | | | | | | |
| ACTUAL SIGNATURE
 | | | | TITLE (SPECIFY)
M.D. Assistant MEDICAL EXAMINER | | | | DATE SIGNED 2-7-82 | | | | | |
| EXAMINER'S NAME (TYPE OR PRINT)
Ann M. Dixon, M.D. | | | | ADDRESS
111 Penn St. | | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)
Burial | | | | 23b. DATE
2/12/82 | | 23c. NAME OF CEMETERY OR CREMATORY
Arbutus Memorial Park | | | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
Arbutus Md | | | |
| 24. FUNERAL DIRECTOR
NAME ADDRESS
William C. March F/H 1101 E. North Avenue | | | | | | 25a. DATE REC'D. BY REGISTRAR BY REGISTRAR SIGNATURE
FEB 9 1982  | | | | | | | |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

135 15 35 030 2 9 1

MEDICAL CERTIFICATION

| STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH | | | | 8 2 0 3 9 7 6 | | | |
|---|--|---|--|--|--|--|--|
| 1. FOR
STATE
REGISTER | | | | REG. NO. | | | |
| 1. DECEASED NAME
(TYPE OR PRINT) FRANK ATKINSON LUCAS | | | | 2a. DATE OF DEATH
MONTH DAY YEAR
2.14.82 | | 2b. HOUR
1245 P M | |
| 3. SEX
Male | | 4. RACE
White | | 5. DATE OF BIRTH
MONTH DAY YEAR
Dec. 13, 1902 | | 6. AGE (IN YEARS LAST BIRTHDAY)
79 | |
| 7. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
Maryland | | 7b. CITIZEN OF WHAT COUNTRY?
USA | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
Baltimore City MD. | |
| 10. CITY OR TOWN OF DEATH
BALTIMORE | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
GOOD SAMARITAN HOSP | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
Civil Engineer | | 12b. KIND OF BUSINESS OR INDUSTRY
Dept. of Navy | |
| 13. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)
13a. STATE Maryland 13b. COUNTY Baltimore 13c. CITY OR TOWN Towson | | | | 13d. INSIDE CITY LIMITS?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 13e. STREET ADDRESS
121 Versailles Circle | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
Charles K. Lucas | | | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
Edith Atkinson | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
No | | 16b. SOCIAL SECURITY NO.
577-36-9969 A | | 17. INFORMANT
ADDRESS
Mrs. Kathryn R. Lucas Same | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for 1a, 1b, and 1c)
PART 1. DEATH WAS CAUSED BY
IMMEDIATE CAUSE (a) CARDIORESPIRATORY ARREST
0389
DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost
(b) SEPSIS PROB: PNEUMONIA
DUE TO, OR AS A CONSEQUENCE OF
(c) | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (b) | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) | | | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK | | 21e. PLACE OF INJURY
(AT HOME STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 2-12-82 to 2-14-82 that (I) (we) lost
saw the deceased alive on 2-14-82 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated
above, (I) (we) (did) (did not) view the body after death. | | | | | | | |
| 22b. SIGNATURE
<i>[Signature]</i> | | | | DEGREE
M.D. ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> | | 22c. DATE SIGNED
2-14-82 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
Dr. Z. MIN | | | | 22e. ADDRESS
5601 Loch Raven Blvd. | | | |
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)
Burial | | 23b. DATE
Feb. 17, 1982 | | 23c. NAME OF CEMETERY OR CREMATORY
Druid Ridge | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
Pikesville, Balto., Co., Md. | |
| 24. FUNERAL DIRECTOR
NAME
Mitchell-Wiedefeld Home, Inc. Balto., Md. 21212 | | | | DATE REC'D. BY REGISTRAR
FEB 18 1982 | | | |

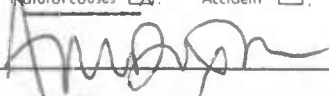
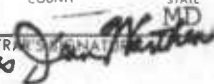


SECRET
CONFIDENTIAL

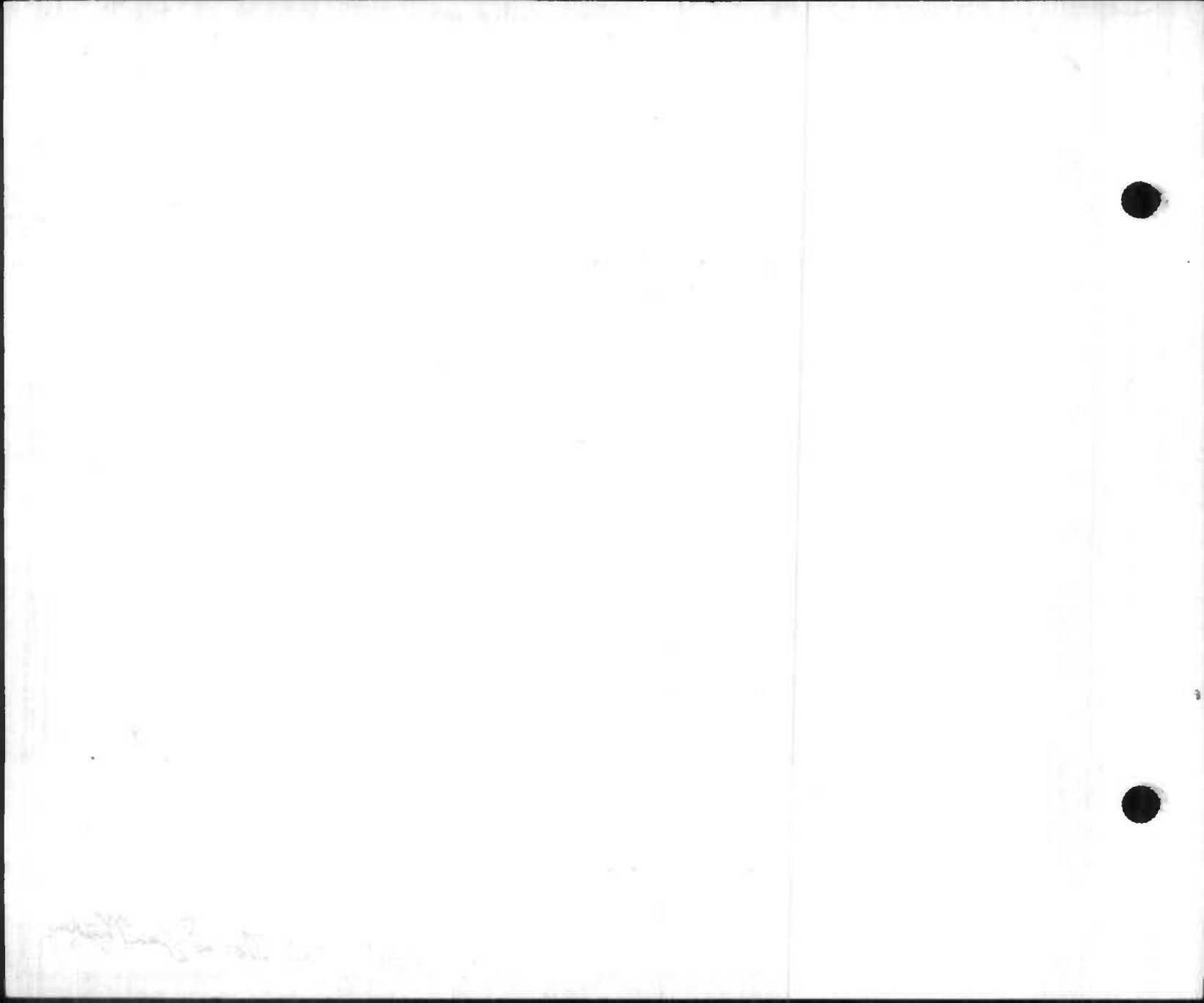
[Handwritten signature]
20-11-11

100-11-11
CONFIDENTIAL
SECRET

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED IN THE DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

| STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH | | | | | | | | | | REG. NO. 2 0 3 9 7 7 | | | |
|--|--|------------------|--|---|--|---|--|---|---|---|---|--|--|
| 1- STATE REGISTRAR | | | | | | | | | | | | | |
| 1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST
CARRIE E. LUCH (Lush) | | | | | | | | | | 2b. DATE KNOWN OF DEATH ESTIMATED <input checked="" type="checkbox"/> MONTH DAY YEAR
2 6 19 82 | | 7b. HOUR
M | |
| 3. SEX
female | | 4. RACE
negro | | 5. DATE OF BIRTH MONTH DAY YEAR
3 16 08 | | 6. AGE (IN YEARS LAST BIRTHDAY) YRS.
73 | | IF UNDER 1 YR. MONTHS DAYS
IF UNDER 24 HRS. HOURS MIN. | | 2c. DATE PRONOUNCED DEAD MONTH DAY YEAR
2 6 19 82 | | 2d. HOUR
12:14 a.m. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
N.C. | | | | 7b. CITIZEN OF WHAT COUNTRY?
USA | | | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | | | 9. BALTIMORE CITY OR COUNTY OF DEATH
Baltimore City MD. | |
| 10. CITY OR TOWN OF DEATH
Baltimore | | | | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
2022 E. 31st St. | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | | | | 12b. KIND OF BUSINESS OR INDUSTRY | |
| 13a. STATE
MD | | | | 13b. COUNTY | | 13c. CITY OR TOWN
Baltimore | | 13d. INSIDE (CITY LIMITS?) YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS
2022 E. 31st St. | | | |
| 14. FATHER'S NAME FIRST MIDDLE LAST
Willie Woods | | | | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST
Maggie Johnson | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)
No | | | | 16b. SOCIAL SECURITY NO.
220-05-0181 | | | | 17. INFORMANT ADDRESS
Carrie Mae Barnes 2022 E. 31st. St. | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I DEATH WAS CAUSED BY:
4292 IMMEDIATE CAUSE (a) Arteriosclerotic cardiovascular disease
Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause lost.
(b) _____
(c) _____
DUE TO, OR AS A CONSEQUENCE OF
DUE TO, OR AS A CONSEQUENCE OF | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a). | | | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | | | | | | 20. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH | | | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) | | | | | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK AT WORK | | | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | | | | | |
| 22a. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> . | | | | | | | | | | | | | |
| ACTUAL SIGNATURE
 | | | | TITLE (SPECIFY)
M.D. Assistant | | | | MEDICAL EXAMINER | | | | DATE SIGNED
2-6-82 | |
| EXAMINER'S NAME (TYPE OR PRINT)
Ann M. Dixon, M.D. | | | | ADDRESS
111 Penn St. | | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)
Burial | | | | 23b. DATE
2/11/82 | | 23c. NAME OF CEMETERY OR CREMATORY
Baltimore Cem. | | | | 23d. LOCATION CITY OR TOWN
Baltimore | | COUNTY
MD | |
| 24. FUNERAL DIRECTOR NAME
Wm. C. March F/H | | | | | | ADDRESS
1101 E. North Ave. | | | 25a. DATE REC'D. BY REGISTRAR
FEB 8 1982 | | 25b. REGISTRAR SIGNATURE
 | | |

BP



STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 2 0 3 9 7 8

1 - FOR
STATE
REGISTRAR

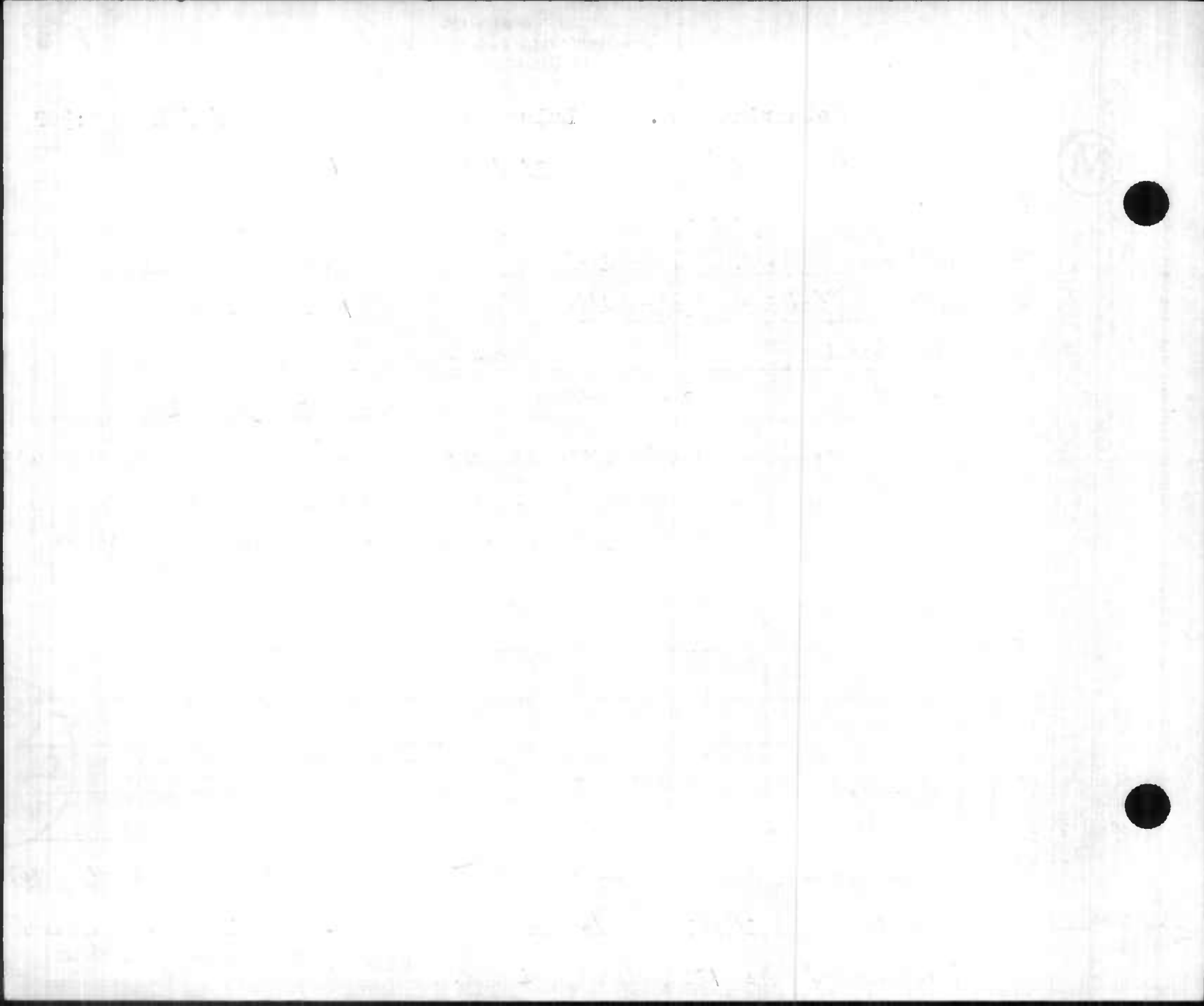
REG. NO.

| | | | | | | | | |
|--|---|---|---|--|--|---|--|--|
| 1. DECEASED NAME
(TYPE OR PRINT) | | | 2a. DATE OF DEATH | | | 2b. HOUR | | |
| FIRST MIDDLE LAST
Catherine K. Lulay | | | MONTH DAY YEAR
2/6/82 | | | HOURS MIN.
9:30 PM | | |
| 3. SEX | 4. RACE | 5. DATE OF BIRTH | 6. AGE (IN YEARS LAST BIRTHDAY) | | | IF UNDER 1 YEAR | | |
| Female | White | MONTH DAY YEAR
3/5/00 | 81 YRS | | | MONTHS DAYS HOURS MIN. | | |
| 7a. BIRTHPLACE
(STATE OR FOREIGN COUNTRY) | 7b. CITIZEN OF WHAT COUNTRY? | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 9. BALTIMORE CITY OR COUNTY OF DEATH | | | | | |
| Maryland | U.S.A. | | Baltimore City MD. | | | | | |
| 10. CITY OR TOWN OF DEATH | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE) | | | 12b. KIND OF BUSINESS OR INDUSTRY | | |
| Baltimore | St. Agnes Hospital | | Retail | | | Sales | | |
| 13a. STATE | 13b. COUNTY | 13c. CITY OR TOWN | 13d. INSIDE CITY LIMITS?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | 13e. STREET ADDRESS | | |
| Maryland | Baltimore | Catonsville | | | | 801 Winters Lane | | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
Robert Kehring | | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
Rosa Kemp | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> OR UNKNOWN) | | | 16b. SOCIAL SECURITY NO.
347 07 5065 | | | 17. INFORMANT ADDRESS
Bruce A. Kent 5300 East Drive | | |

| | | |
|--|--|--|
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART 1. DEATH WAS CAUSED BY
IMMEDIATE CAUSE (a) Respiratory failure
1809
DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last
(b) BRAIN METS or PULMONARY EMBOLUS
DUE TO, OR AS A CONSEQUENCE OF
(c) CA OF CERVIX, LIVER, BONE METS
2 years. | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
|--|--|--|

| | | | |
|--|--|--|--|
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) | | | |
| 19a. DATE OF OPERATION | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK AT WORK | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | |
| 22a. I certify that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) lost saw the deceased alive on _____, 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | |
| 22b. SIGNATURE
Rafael Oliver-Vidaud
DEGREE
MD | | 22c. DATE SIGNED
2/6/82 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
RAFAEL OLIVER-VIDAUD | | 22e. ADDRESS
1209 St Agnes CA. Balto MD 21207 | |

| | | | |
|---|----------------------------|---|--|
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)
burial | 23b. DATE
2/9/82 | 23c. NAME OF CEMETERY OR CREMATORY
Glen Haven | 23d. LOCATION
CITY OR TOWN COUNTY STATE
Glen Burnie A.A. Maryland |
| 24. FUNERAL DIRECTOR
NAME ADDRESS
Ambrose Funeral Home 1328 Sulphur Spring Rd. | | 25a. DATE REC'D. BY REGISTRAR 25b. REGISTRAR'S SIGNATURE
FEB 8 1982 | |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

DHMH - 16 50M 1/81
(VRA 15, 4)

1 - FOR
STATE
REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 2 0 3 9 7 9

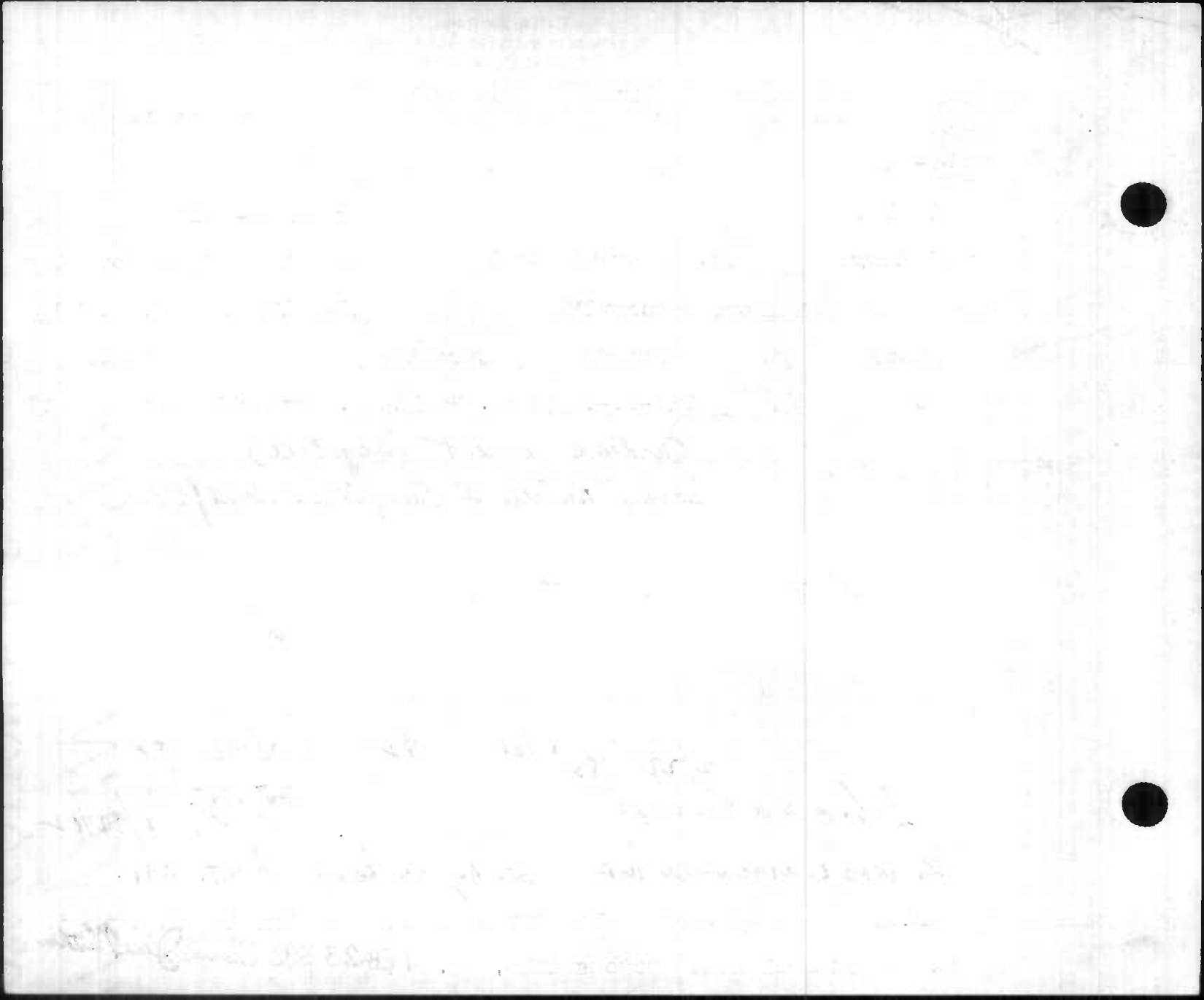
REG. NO.

| | | | | | | | | | |
|---|--|---|--|---|--|--|--|--|--|
| 1. DECEASED NAME
(TYPE OR PRINT)
James Hiram Luttrell
JAMES H LUTTRELL | | | 2a. DATE OF DEATH
MONTH DAY YEAR
2 22 82 | | | 2b. HOUR
930 P M | | | |
| 3. SEX
Male | | 4. RACE
white | | 5. DATE OF BIRTH
MONTH DAY YEAR
4 28 02 | | 6. AGE (IN YEARS LAST BIRTHDAY)
79 YRS. | | 7. IF UNDER 1 YEAR
MONTHS DAYS
IF UNDER 24 HRS
HOURS MIN. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
Virginia | | 7b. CITIZEN OF WHAT COUNTRY?
USA | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
Baltimore City MD. | | | |
| 10. CITY OR TOWN OF DEATH
Baltimore | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
St. Agnes Hospital | | | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
Mechanic | | 12b. KIND OF BUSINESS OR INDUSTRY
Floor Covering | |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)
13a. STATE
Maryland | | | | 13b. CITY OR TOWN
Catonsville | | 13c. STREET ADDRESS
106 Hillside Rd. 21228 | | | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
James W. Luttrell | | | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
Caroline Sisson | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
No | | 16b. SOCIAL SECURITY NO.
(IF YES, GIVE WAR OR DATES)
N/A | | 17. INFORMANT
ADDRESS
Mrs. Hallie D. Luttrell Same as # 13 | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))
PART 1. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>Cardiac arrest (asystole)</u>
4292
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.
(b) <u>Severe ASCVD & Congestive Heart failure.</u>
DUE TO, OR AS A CONSEQUENCE OF
(c) <u>Arterial Hypertension</u> | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <u>Arterial Hypertension</u> | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | | | |
| 21d. INJURY OCCURRED
WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>2/21</u> 19 <u>82</u> , to <u>2/22</u> 19 <u>82</u> , that (I) (we) lost the deceased alive on <u>2/22</u> 19 <u>82</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death. | | | | | | | | | |
| 22b. SIGNATURE
<u>Ricardo L. MacNabb</u> | | | | DEGREE
ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL STAFF PHYSICIAN <input checked="" type="checkbox"/> | | 22c. DATE SIGNED
<u>2/22/82</u> | | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
Ricardo L. MacNabb M.D. | | | | 22e. ADDRESS
St. Agnes Hosp. Balt. Md. | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)
Burial | | 23b. DATE
2/26/82 | | 23c. NAME OF CEMETERY OR CREMATORY
Glen Haven Mem Pk | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
Glen Burnie A.A. Md. | | | |
| 24. FUNERAL DIRECTOR
NAME
MacNabb Funeral Home | | | | ADDRESS
Catonsville, Md. | | 25a. DATE REC'D. BY REGISTRAR
FEB 23 1982 | | 25b. REGISTRAR'S SIGNATURE
<u>James J. Nathan</u> | |

MEDICAL CERTIFICATION

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BP



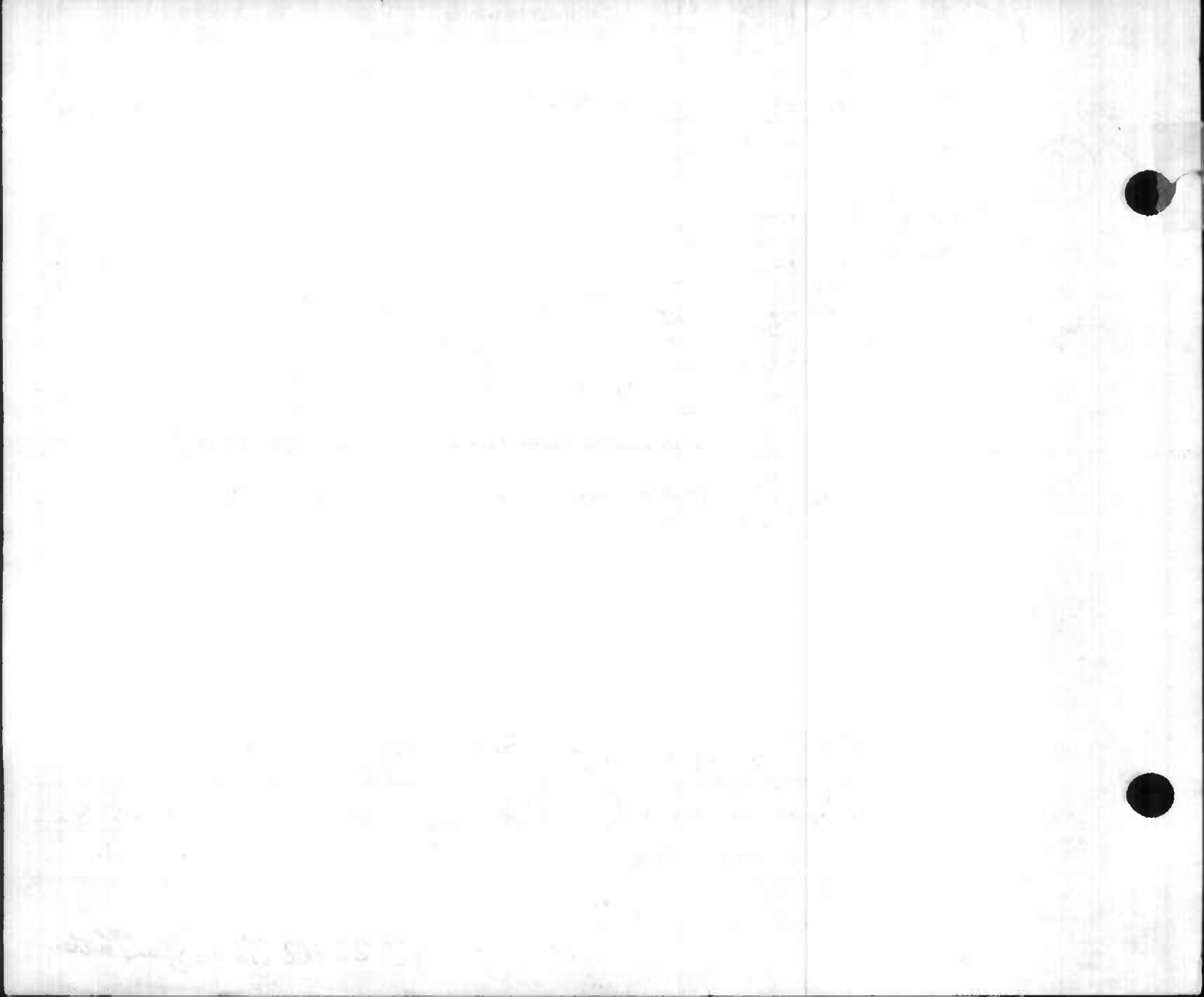
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be contacted at 1-800-338-3839.

| STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH | | | | 8 2 0 3 9 8 0 | | | |
|---|--|--|--|---|--|--|--|
| 1. FOR STATE REGISTRAR | | | | REG. NO. | | | |
| 1. DECEASED NAME
(TYPE OR PRINT) ELLA LYNCH | | | | 2a. DATE OF DEATH MONTH DAY YEAR
2 - 25 - 82 | | | |
| 3. SEX Female | | | | 2b. HOUR 1 A M | | | |
| 4. RACE Black | | 5. DATE OF BIRTH
MONTH DAY YEAR
1 1 09 | | 6. AGE (IN YEARS LAST BIRTHDAY)
72 | | IF UNDER 1 YEAR
MONTHS DAYS
IF UNDER 72 HRS
HOURS MIN. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
Fla. | | 7b. CITIZEN OF WHAT COUNTRY?
USA | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
Baltimore City MD | |
| 10. CITY OR TOWN OF DEATH
Baltimore | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
Provident Hospital | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE) | | 12b. KIND OF BUSINESS OR INDUSTRY | |
| 13a. STATE MD | | | | 13b. COUNTY Baltimore | | | |
| 13c. CITY OR TOWN Baltimore | | | | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | |
| 13e. STREET ADDRESS
2121 Windsor Garden Lane | | | | | | | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
Morris Staney | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
Lucy Stevens | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)
No | | 16b. SOCIAL SECURITY NO.
216-05-3417 | | 17. INFORMANT
ADDRESS
Willie L. Spencer 2307 N. Pulaski St. | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART 1. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) cardio-respiratory arrest
2639
DUE TO, OR AS A CONSEQUENCE OF
(b) Malnutrition, Dehydration
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last
(c) | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) | | | |
| 21d. INJURY OCCURRED
WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 2 - 25 - 19 82 to 2 - 25 - 19 82 , that (I) (we) lost
saw the deceased alive on 2 - 25 - 19 82 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated
above, (I) (we) (did) (did not) view the body after death. | | | | | | | |
| 27b. SIGNATURE
H. Devadoss | | | | DEGREE
MD
ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> | | 27c. DATE SIGNED
2/25/82 | |
| 27d. PHYSICIAN'S NAME (TYPE OR PRINT)
H Devadoss | | | | 27e. ADDRESS
Provident Hospital. | | | |
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)
Burial | | 23b. DATE
3/1/82 | | 23c. NAME OF CEMETERY OR CREMATORY
King Memorial Pk. | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
Baltimore Co. MD | |
| 24. FUNERAL DIRECTOR
NAME
Wm. C. March F/H | | | | ADDRESS
1101 E. North Ave. | | 25a. DATE REC'D. BY REGISTRAR 25b. REGISTRAR'S SIGNATURE
FEB 26 1982 James J. Nathan | |

BP



TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL HOME. GIVE PAGES 4 AND 5 TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR THE FUNERAL DIRECTOR. PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITH PAGES 3 AND 4, IN THE DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

1- FOR
STATE
REGISTRAR

| | | | | | | | | |
|--|---------|--|--------------------------|--|---|---|---------------------|-----------------------------------|
| 1. DECEASED NAME
(TYPE OR PRINT) | | | 2a. DATE KNOWN OF DEATH | | | 2b. HOUR | | |
| TIMOTHY Tighe LYNCH | | | 2. 11 19 82 | | | M | | |
| 3. SEX | 4. RACE | 5. DATE OF BIRTH | 6. AGE (IN YEARS) | IF UNDER 1 YR. | IF UNDER 24 HRS. | 7c. DATE PRONOUNCED DEAD | 7d. HOUR | |
| male | white | March 28, 1960 | 21 YRS. | | | 2 11 19 82 | 8:08 P M | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) | | 7b. CITIZEN OF WHAT COUNTRY? | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH | | |
| Maryland | | U.S.A. | | | | Baltimore City, MD | | |
| 10. CITY OR TOWN OF DEATH | | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | | 12b. KIND OF BUSINESS OR INDUSTRY |
| Baltimore | | University Hospital | | | | A.A.I. | | Quality Control Specialist |
| 13a. STATE | | | 13b. CITY OR TOWN | | 13c. INSIDE CITY LIMITS? | | 13d. STREET ADDRESS | |
| Maryland | | | Baltimore | | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 208 Ridgefield Road | |
| 14. FATHER'S NAME | | | 15. MOTHER'S MAIDEN NAME | | | | | |
| Charles E. Lynch, Jr. | | | Ann Marie Gugerty | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? | | | 16b. SOCIAL SECURITY NO. | | 17. INFORMANT ADDRESS | | | |
| No | | | 216-88-2344 | | Mr. Charles E. Lynch, Jr. Same as #13. | | | |

| | | |
|---|--|--|
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART I DEATH WAS CAUSED BY: | | |
| IMMEDIATE CAUSE (a) Multiple injuries | | |
| DUE TO, OR AS A CONSEQUENCE OF | | |
| (b) | | |
| DUE TO, OR AS A CONSEQUENCE OF | | |
| (c) | | |

| | | | |
|---|--|---|--|
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | |
| | | | |
| 20. AUTOPSY? | | | |
| YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | |
| 21a. EXTERNAL CAUSE WAS | | 21b. TIME OF INJURY | |
| UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH | | HOUR XXX MONTH DAY YEAR | |
| | | 7:05 P.M. 2-11-1982 | |
| 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) | | | |
| Driver in auto/multiple vehicle collision. | | | |
| 21d. INJURY OCCURRED | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) | |
| WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK | | road | |
| 21f. LOCATION | | CITY OR TOWN | |
| Ridgefield & York Rds. | | Balto. Md. | |
| 22a. I certify that I took charge of the remains described above, held on | | | |
| Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion | | | |
| death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> | | | |
| ACTUAL SIGNATURE | | TITLE (SPECIFY) | |
| Ann M. Dixon, M.D. | | M.D. Assistant MEDICAL EXAMINER | |
| EXAMINER'S NAME (TYPE OR PRINT) | | DATE SIGNED | |
| | | 2-12-82 | |

| | | | | | | | |
|--|--|-------------------------------|--|------------------------------------|--|--------------------------|--|
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) | | 23b. DATE | | 23c. NAME OF CEMETERY OR CREMATORY | | 23d. LOCATION | |
| Burial | | Feb. 15, 1982 | | Dulaney Valley Cemetery | | Cockeysville Balto., Md. | |
| 24. FUNERAL DIRECTOR | | 25a. DATE REC'D. BY REGISTRAR | | 25b. REGISTRAR'S SIGNATURE | | | |
| Ruck Towson Funeral Home, Inc. Towson, Md. 21204 | | FEB 16 1982 | | Ann M. Dixon | | | |

